IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI

CENTRAL UNITED LIFE INSURANCE COMPANY,	)	
Petitioner,	)	
v.	)	Case No. 09AC-CC00537
JOHN M. HUFF, DIRECTOR OF THE DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION, STATE OF MISSOURI,	)	
Respondent.	)	

Appeal from the Findings of Fact, Conclusions of Law and Order Of the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration

RESPONDENT'S BRIEF

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JURISDICTIONAL STATEMENT

This case is an appeal for judicial review of the August 27, 2009 Findings of Fact, Conclusions of Law and Confidential Final Order Accepting Final Examination Report as Filed issued by the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration in *In re Central United Life Insurance Co., Missouri Market Conduct Examination,* No. 090814644C, accepting the Final Market Conduct Examination Report of Central United Life Insurance Company as filed pursuant to 20 CSR 100-8.018(1)(G)1.

This Court has jurisdiction to hear Petitioner's petition for judicial review in a contested case pursuant to § 536.100 and § 374.055 RSMo (Supp. 2009) and consistent with Article V, Section 18 of the Missouri Constitution.

STATEMENT OF FACTS

A. Introduction

Petitioner Central United Life Insurance Company (the "Company") marketed and sold cancer insurance policies in Missouri. These were guaranteed renewable policies subject only to the Company's right to amend premium payments. These policies agreed to pay policyholders the "actual charges," an undefined phrase, for certain covered medical services. The marketing materials utilized by the Company and its predecessors indicated that the Company would pay for these medical services "regardless" of or "in addition to" other insurance the policyholder might have, and for years, the Company did pay the medical provider's actual charges without regard to payments made by its policyholders' major medical plans or other medical care coverage.

In February 2003, the Company changed the way it administered these policies. Now the Company would only reimburse its policyholders the amount their medical providers contractually agreed to accept from other health carriers for their services instead of what these same providers would have charged those who lacked other health coverage. The Company did not immediately notify its policyholders that it was making this unilateral change, and it did not offer its policyholders an option to accept this change or pay higher premiums. Rather, it made the change to effectively reduce the benefits being collected by its cancer-stricken policyholders and continue collecting premiums from its healthy policyholders without any notice to the latter group of the change. In this way, the Company continued to collect premiums from the maximum percentage of its non-cancer-stricken policyholders, some of whom would have left if they had been exposed to higher premiums or reduced benefits, and unilaterally and without consideration reduced the amounts paid to its cancer-stricken policyholders.

B. Statement of Facts

During 1997, the Company acquired guaranteed renewable cancer insurance policies that had been issued by Dixie National Life Insurance Company ("Dixie") and Commonwealth National Life Insurance Company ("Commonwealth"). Tr. 36, 83; Company Brief, p. 7, ¶ 7. The Company administered Dixie policy forms CP-1004 and CP-1005 and Commonwealth policy forms CEP-350-MAX-COMB, CEP-93ULT, and CEP-93CONV. Ex. 20(7).[1] Sometime after 1997, the Company developed and marketed its own guaranteed renewable cancer insurance policies via policy forms CP-1003-MO and CP3000AMO. *Id.*; Tr. 35-37. Under all the policies, the only term that the Company could unilaterally change was the amount of the premium it charged the policyholders. *See, e.g.*, Ex. 20(7, p. 2).

When the Company acquired closed blocks of business from Commonwealth and Dixie, it did not then, or thereafter, file a statement with the Department to withdraw Commonwealth or Dixie's advertising forms. Those advertisements included the following: [2]

1. Form BCEP-94 advertised "actual charge" benefit Policy Form CEP-93ULT. Ex. 20(5, pp. 9-12). On the lower half of page 3 of Form BCEP-94, below the bolded, large type heading, "**Why does this outstanding policy deserve your consideration?**" are six bullet point items in bold type. The second bullet point states: **It pays regardless of other insurance you may have!**" *Id.* at p. 11.

2. Form CP-1005-Rev.3/88 advertised "actual charge" benefit Policy Form CP-1005. Ex. 20(5, pp. 6-7). Form CP-1005-Rev.3/88 lists six items under the heading Additional Benefits. The first and last bullet items appear in bold type and state:

- "***Pays in addition to all other insurance**"
- "***Pays directly to you**"

[1] Exhibit numbers correspond to the item numbers on the Index to the Record on Review. The exhibits numbers assigned to specific exhibits presented at the hearing appear in parentheses. Therefore, Ex. 20(7) references the Record on Review item 20, and exhibit 7 within that item.

[2] The bold, underline and/or capitalization appear in the original documents for the following five sub-points.

3. Form NCP-5-(Rev.9/92) advertised "actual charge" benefit Policy Form CP-1004. Ex. 20(5, pp. 3-4, 17-20). Form NCP-5-(Rev.9/92) stated in bold type and in the largest font on the page "**PAYS IN ADDITION.**" Below that, also in bold type but in slightly smaller font, reads "**to any other insurance, private or governmental, including Medicare, and directly to you or whomever you designate. No reduction in benefits at any age.**" *Id.* at p. 5.

4. Form CP-1003-GN-7/96 advertised "actual charge" policy form CP-1003. At the bottom of the second page, Form CP-1003-GN-7/96 includes a list of six items describing the policy on the front page. The second item on this list states, "**PAYS IN ADDITION** to any other insurance, private or government, including Medicare, and directly to you or whomever you designate." Ex. 20(5, pp. 13 – 16).

5. Forms CP3000A 0102-MO and CP3000A-CC-0202 (AR, IL, MO) included substantially the following language: "**PAYS IN ADDITION to any other insurance, private or government, including Medicare, and directly to you or whomever you designate.**" Forms CP3000A 0102-MO and CP3000A-CC-0202 (AR, IL, MO) do not include a definition or explanation of the term "actual charge." Ex. 20(6, pp. 5-14).

The policies administered and initiated by the Company contain "actual charge" benefits whereby the Company agrees to pay benefits to policyholders based on the "actual charge" for a variety of medical and non-medical services related to the treatment of cancer. Company Brief, p. 7, ¶ 9. None of the "actual charge" benefit policies or marketing materials at issue in this litigation contain a definition of the term "actual charge" or an explanation that "actual charge" benefit claims would be administered based on "the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided" until December 2003. Company Brief, p. 8, ¶ 10; Report, A-24.[3]

Prior to February 1, 2003, the Company paid "actual charge" benefits based on bills, statements, or whatever document the policyholder received from the health care provider. Tr. 49; Company Brief, p. 8, ¶ 11. By February 2003, health care providers frequently accepted less

[3] The Market Conduct Final Examination Report ("Report") appears in the Record on Review, Exhibit 20, which contains all of the hearing exhibits. For convenience, a copy of the Findings of Fact, Conclusions of Law and Confidential Final Order Accepting Final Examination Report as Filed ("Order") is attached in the Addendum. The Report is attached to the Order. A-24, for example, denotes page 24 of the Addendum.

than the "actual charge" as full payment based upon discounts negotiated with major medical insurers and Medicare. Company Brief, p. 8, ¶ 12.

Beginning February 1, 2003, the Company changed how it administered "actual charge" claims. Tr. 50. From that date forward, the Company administered "actual charge" claims such that "actual charge" now meant "the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided." Ex. 20(4); Tr. 50. Beginning on or after February 1, 2003, the Company also began requiring Explanation of Benefit forms (EOBs), Medicare Benefit Summaries, or other proof of loss documentation to show "the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided." Ex. 20(4); Tr. 50. The Company did not notify its sales agents of the changed administration until sometime in July 2003. Tr. 192. The Company changed its administration procedures, at least in part, to minimize premium increases. Company Brief, p. 9, ¶15.

Because some policyholders had "been relying on that amount," the Company continued to administer existing or "current claim status" "actual charge" claims in the same manner as "actual charge" claims administered prior to February 2003. Tr. 51-52. These policyholders would have been paid a lesser amount had the Company applied the new claims administration method.

The Company also continued to pay new "actual charge" claims filed by policyholders without other primary health insurance in the same manner as "actual charge" claims administered prior to February 2003. Tr. 104-105. This is because policyholders without other primary health insurance do not receive EOBs or Medicare Benefit Summaries that reflect lesser

negotiated rates. In some cases, otherwise uninsured policyholders were paid a larger amount by the Company than patients and policyholders with other insurance. *Id*

On July 1, 2003, the Company sent a self-described "IMPORTANT NOTICE REGARDING CANCER CLAIMS" to all existing "actual charge" benefit policyholders regarding its changed administration of "actual charge" claims. Tr. 60; Ex. 20(4). The notice informed policyholders that, because of this change, EOBs, Medicare Benefit Summaries, or similar documents would be required as part of proofs of loss to show the amount of money a provider agreed to accept as full payment for covered services. *Id.*

The Company marketed Policy Form CP3000AMO, which did not include a definition of "actual charges" from July 1998 until December 2003. Ex. 20(3). The Company never revised the marketing materials used in Policy Form CP3000AMO solicitations to incorporate a definition or explanation of "actual charge" before it discontinued marketing the policy. Tr. 188.

The term "actual charge" was not defined or explained in any of the Company's Missouri marketing materials until October 2003. Report, A-24; Company Brief p. 8, ¶ 10. On or about October 16, 2003, the Company mailed Endorsement Form CP3ACEND to existing policyholders and began attaching Endorsement Form CP3ACEND to new Policy Form CP3000AMO policies. Report, A-31; Ex. 20(4). Endorsement Form CP3ACEND included a definition of "actual charge." Ex. 20(4).

Prior to October 2003, none of the Company's marketing materials explained that "actual charge" benefit claims would be administered based on "the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided." Tr. 187-188. None of the marketing materials created by Dixie or Commonwealth that advertised policies for which the Company was liable explained that "actual

charge" benefit claims would be administered based on "the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided." *Id.* No advertisement for Dixie, Commonwealth, or the Company's "actual charge" benefit policies, prior to October 2003, explain that the amount of "actual cost" benefits payable may depend upon the policyholders' "other insurance." *Id.*

Long after the Company changed how it administered "actual charge" policies in February 2003, it received correspondence from two Department employees regarding the practice in October 2003, August 2005, September 2005, and October 2005. Ex. 20(W, X, Y, and Z). The Department employees were assigned to the Division of Consumer Affairs. *Id.* Neither had authority to speak for the Department as a whole or compel the Company to take alternative action regarding its payment of "actual charge" benefits. Tr. 214.

C. Procedural History

Through the Division of Market Regulation ("Division"),[4] the Director initiated a market conduct examination of the Company covering a period from January 1, 2002 through December 31, 2004. Report, A-23. The primary purpose of the examination was to determine whether the Company complied with Missouri laws and Department regulations in its marketing, underwriting and administration of cancer and specified disease health insurance policies. The examination took place in 2006 and was conducted by James (Jim) Mealer and Jim Casey on behalf of the Department. Report, A-39. The examination was completed on August 26, 2008, the date the examiners issued their draft report. *Id.* Between August 2008 and June 2009, the Division and the Company engaged in discussions concerning the draft report and other pending litigation (*Skelton v. Central United Life Ins. Co.*) pursuant to the process outlined in § 374.205

[4] The Division of Market Regulation, which was responsible for conducting the market conduct examination, is now known as the Division of Insurance Market Regulation.

and 20 CSR 100-8.018 Post-Examination Procedure whereby the Company is authorized to submit written comments and negotiate modifications to the examination report. *See* Ex. 20(MM); Company Letter, A-42.

The Final Market Conduct Examination Report ("Report"), dated July 10, 2009, was delivered to the Company on or about July 13, 2009. Report, A-39; Company Brief, p. 12, ¶ 31. The Report criticized, *inter alia,* the Company's changed administration of "actual charge" benefit policies which the examiners allege resulted in 1) a reduction in the amount of benefits payable; 2) an increase in consumer complaints; 3) increased litigation against the Company; and 4) more time consuming claims processing because the Company began to ask for Explanations of Benefits from policyholders' primary health plan or Medicare benefits summaries. Report, A-20 - 39.

On August 13, 2009, the Company petitioned the Director to modify the Report and for a hearing. Company Brief, p. 12, ¶ 32; Request to Modify and for Hearing, SROR 1.[5] On August 14, 2009, the Director appointed Department Senior Enforcement Counsel Mary Erickson to serve as hearing officer and ordered a hearing for August 24, 2009. Ex. 1. On August 17, 2009, the Company requested that the hearing officer continue the hearing until to August 25, 2009. Ex. 3. This request was granted. *Id.* On August 18, 2009, the Company filed a second request for a continuance. Ex. 4. The hearing officer denied this request. Ex. 10.

At the hearing held on August 25, 2009, the Division and the Company appeared by counsel, presented documentary and testamentary evidence, and cross-examined witnesses. Ex. 20. Both parties submitted proposed findings of fact, conclusions of law and order. Ex. 11 and 18. On August 27, 2009, the Director issued his Findings of Fact, Conclusions of Law and

[5] This Request has been included in the Supplemental Record on Review (SROR). SROR 1 denotes the item number in the Supplemental Record on Review filed by separate motion.

Confidential Final Order Accepting Final Examination Report as Filed ("Order") under 20 CSR 100-8.018(1)(G)(1). Order, A-1. The Order accepted the Report, dated July 10, 2009, as filed and ordered the Enforcement Section of the Department to initiate appropriate legal and regulatory actions consistent with the findings in the Report and Order. Order, A-18. This appeal followed.

STANDARD OF REVIEW

Article V, § 18 of the Missouri Constitution prescribes that judicial review of the final decision of an administrative agency "shall include the determination whether the same [is] authorized by law, and in cases in which a hearing is required by law, whether the same [is] supported by competent and substantial evidence upon the whole record."

For review of an agency decision in a contested case, § 536.140.2 RSMo (Supp. 2009), requires the reviewing Court to determine whether the agency action:

(1) Is in violation of constitutional provisions;
(2) Is in excess of the statutory authority or jurisdiction of the agency;
(3) Is unsupported by competent and substantial evidence upon the whole record;
(4) Is, for any other reason, unauthorized by law;
(5) Is made upon unlawful procedure or without a fair trial;
(6) Is arbitrary, capricious or unreasonable; or
(7) Involves an abuse of discretion.

In reviewing the agency decision, the Court must "defer to the [agency's] determination regarding 'weight of the evidence and the credibility of witnesses.'" *Lagud v. Kansas City Bd. of Police Comm'rs*, 272 S.W.3d 285, 290 (Mo. App. W.D. 2008) (citation omitted). If the agency "has reached one of two possible conclusions from the evidence, [the] reviewing authority will not reach a contrary conclusion even if it could reasonably do so." *Id.* The reviewing Court defers to the agency's findings of fact, if supported by the evidence. *Id.*; *Teague v. Mo. Gaming Comm'n*, 127 S.W.3d 679 (Mo. App. W.D. 2003). Courts presume that decisions rendered by an administrative agency are correct, in that a strong presumption exists of validity in favor of administrative decisions. *White v. Division of Family Servs.*, 634 S.W.2d 258, 260 (Mo. App. E.D. 1982). "A decision is not arbitrary or unreasonable merely because the court on appeal might have reached a contrary conclusion upon the same evidence." *Chrismer v. Missouri Div. of Family Servs.*, 816 S.W.2d 696, 700 (Mo. App. W.D. 1991). That the court

might have reached an opposite conclusion from a *de novo* consideration of the record or evidence is neither of consequence nor determinative. *Morton v. Missouri Air Conservation Comm'n*, 944 S.W.2d 231, 236 (Mo. App. S.D. 1997). "Where the evidence before the agency would warrant either of two opposing conclusions, [the court is] bound by the agency's findings." *Id.* The Court "gives no deference to the agency's conclusions of law, which are reviewed *de novo*." *Colyer v. State Bd. of Registration for the Healing Arts*, 257 S.W.3d 139, 143 (Mo. App. W.D. 2008) (citations omitted).

The scope of this Court's review of the administrative decision is limited to matters that arose before the administrative agency and deals only with questions of law that appear on the face of the record. *Boyer v. City of Potosi*, 38 S.W.3d 430, 434 (Mo. App. E.D. 2000); § 536.140.3. This Court must examine the record in the light most favorable to the Director's Order. *State ex rel. Family Support Division v. Foster,* 174 S.W.3d 589, 590 (Mo. App. S.D. 2005).

The Company, as the party aggrieved by Director's administrative decision, bears the burden of persuasion before this Court to show why the administrative decision is in error. *Versatile Mgmt. Group v. Finke,* 252 S.W.3d 227, 232 (Mo. App. E.D. 2008). In accordance with § 536.140.5, this Court shall "render judgment affirming, reversing, or modifying" the Director's Order.

ARGUMENT

A. The Director did not err in the form of his Findings of Fact because the Findings of Fact are not in violation of constitutional provisions or in excess of the statutory authority or jurisdiction of the Director, are supported by competent and substantial evidence upon the whole record, are not made upon unlawful procedure or without a fair trial, are not arbitrary, capricious or unreasonable and are not an abuse of discretion, in that (1) the Company failed to object to and claims no error regarding the administration of the hearing pursuant to 20 CSR 100-8.018; (2) the specific regulation governing the procedures before the Director did not require a response to each proposed finding of fact; and (3) the Director's Order resolved all factual disputes in unequivocal, affirmative findings of fact from which this Court can conduct a full and fair review on appeal.

The Company's argument for remand based upon the Director's alleged failure to explicitly rule upon each finding of fact proposed by the Company is without merit because the Director was *not* required to explicitly rule upon each proposed finding of fact, the Director in fact did rule upon the Company's relevant proposed findings of fact, and the extensive record before this Court is sufficient to review the Director's Findings of Fact, Conclusions of Law and Confidential Final Order Accepting Final Examination Report as Filed ("Order").

1. The Company failed to object to and claims no error regarding the resolution of this matter pursuant to 20 CSR 100-8.018.

For three reasons, the Company's argument is too little and too late. First, at the outset of the hearing, the hearing officer announced that the hearing was "being held pursuant to 20 CSR 100-8.018." Tr. 7. The Company made no objection. Second, as part of his Order, the Director held in his Conclusions of Law that the Director's jurisdiction "to initiate and administer this proceeding is found in § 374.205.3 RSMo 2000 and 20 CSR 100-8.018." Order, A-8, ¶ 45; *see also* ¶ 46. Nowhere in its Petition for Review or its Brief does the Company object to, protest or claim error regarding this Conclusion of Law by the Director. Third, the operative regulation, 20 CSR 100-8.018, does not require a ruling on each proposed finding of fact. Hence, not only does the Company's point fail, the Company missed the signposts along the way to avoid this failure.

2. The Order was governed by and is in compliance with 20 CSR 100-8.018.

Title 20 CSR 100-8.018(3) states explicitly what is required of an order issued pursuant to 20 CSR 100-8.018(1)(G)1.:[6]

> All orders entered pursuant to subsection (1)(G) shall be accompanied by findings and conclusions resulting from the director's consideration and review of the examination report, relevant examiner work papers, and written submissions, rebuttals, or comments, if any submitted by the company. A finding issued under subsection (1)(F) shall not be considered a final order. Any order issued under paragraph (1)(G)1. shall be considered a final administrative decision and may be appealed pursuant to section 374.055, RSMo, Chapter 536, RSMo, and 20 CSR 800-1.100 and shall be served upon the company by certified mail, together with a copy of the final examination report. Within thirty (30) days of the issuance of the final findings, as outlined in subsection (1)(G), the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the final report and related orders.

In contrast, the Company relies on 20 CSR 800-1.100(7)(A), a general, Departmental procedural regulation, and in doing so overlooks the fact that this matter was governed by a more specific regulation, 20 CSR 100-8.018, Post-Examination Procedure.

Regulations are interpreted under the same principles of construction as statutes. *Department of Soc. Servs., Div. of Medical Servs. v. Senior Citizens Nursing Home Dist. of Ray Co.*, 224 S.W.3d 1, 10 (Mo. App. W.D. 2007). "Where one statute deals with a particular subject in a general way, and a second statute treats a part of the same subject in a more detailed way, the more general should give way to the more specific." *Anderson ex rel. Anderson v. Ken Kauffman & Sons Excavating, L.L.C.*, 248 S.W.3d 101, 107-108 (Mo. App. W.D. 2008) (internal citation omitted). As the appellate court found in a case relied on by the Company, "[w]here a specific statute exists concerning judicial review of administrative procedures, it is to be followed exclusive of the general provisions for judicial review of administrative decisions found

[6] The Company appeals the Order issued under 20 CSR 100-8.018(1)(G)1.

in Chapter 536." *Hundley v. Wenzel*, 59 S.W.3d 1, 4-5 (Mo. App. W.D. 2001). Company Brief, p. 19.

Significantly, the operative regulation announced by the hearing officer, 20 CSR 100-8.018, does reference the regulation relied upon by the Company, but only as it relates to appeal rights, not in relation to the findings of fact. In another example of contrast between the two regulations, the regulation now relied on by the Company provides how a copy of the order is to be served upon each party: "A copy of the order immediately shall be delivered personally or mailed, postage prepaid, certified or registered to each party and to his/her attorney of record." 20 CSR 800-1.100(7)(A). Compare that with the regulation specifically governing the hearing at issue setting forth a slightly differently procedure for service of an order: "Any order issued under paragraph (1)(G)1. shall be served upon the company by certified mail, together with a copy of the final examination report." 20 CSR 100-8.018(3). The differences between the regulations championed by the parties demonstrates that the more specific administrative procedures in 20 CSR 100-8.018(3) governing Post-Examination Procedure apply, rather than the general regulation espoused by the Company.

The Director properly issued his Order accepting for filing the Report in accordance with 20 CSR 100-8.018(3), which requires no ruling on each proposed finding.

3. The Director's Order resolved all factual disputes in unequivocal, affirmative Findings of Fact for this Court to conduct a full and fair review on appeal.

The Company relies on 20 CSR 800-1.100(7)(A) to assert that the matter should be remanded because the Director's Order failed to contain a ruling upon each fact finding it proposed. However, the Company's argument distorts the regulation upon which it relies. Title 20 CSR 800-1.100(7)(A) states, in relevant part:

> Findings of fact, if set forth in statutory language, shall be accompanied by a statement of the underlying supporting facts. **If a party submits proposed findings of fact which may control the decision or order, the decision or order shall include a ruling upon each proposed finding.** Each conclusion of law shall be supported by authority or reasoned opinion. A decision or order shall not be except upon consideration of the record as a whole or such portion as may be supported by competent and substantial material evidence on the whole record.

20 CSR 800-1.100(7)(A) (bold and underline emphasis added).

It is the Director's viewpoint of what findings may control the decision, not Petitioner's. It is the Director who issues the findings of fact, conclusions of law, and order, based upon consideration of the whole record. Stated otherwise, it is the Director's view, as the adjudicator, who considers the proposed findings and whether such proposed findings may control his decision. The Company cites to no statutes or case law to the contrary. In fact, the Company cannot do so because, as it recognizes in its Standard of Review, the reviewing court defers to the agency's findings of fact, if supported by evidence. Company Brief, p. 16. "The fact-finding function rests with the [agency] and even if the evidence would support either of two findings, the court is bound by the [agency's] factual determination." *Harrington v. Smarr*, 844 S.W.2d 16, 18 (Mo. App. W.D. 1992).

The Company, in a cursory manner, notes its proposed facts which the Director allegedly failed to address in his Order. Also, the Company failed to articulate how those findings "may control the decision or order." 20 CSR 800-1.100(7)(A). The Director fully expects the Company to correct its error in its reply brief. As demonstrated below, any subsequent attempt to do so by the Company will fail because the Director issued findings of fact responsive to the Company's proposed findings[7] and to the issues raised by the Company:

[7] The Company asserts that paragraphs 19-23, 27-29, 32-43, 45-46, 48, 50-53 and 57-62 from its Proposed Findings of Fact, Conclusions of Law and Order were not subject to a specific ruling in the Order. Company Brief, p. 17.

Company's Proposed Findings ¶s 19 and 20: The Company's proposed findings of fact in these paragraphs concern the phrase "actual charge" not being a term of art and its interpretive capacity. While not explicitly addressed in the Director's Order, the change in industry practices, the ambiguity of the phrase, and the Company's response to that industry practice and ambiguity were addressed in the Director's order. Order, A-4, ¶s 17 – 22.

¶ 21: The Company's proposed finding of fact suggested that its marketing materials were literally true and could not be deemed deceptive. First, literal truth may be a defense in defamation, slander, and libel cases, but it is not a defense to alleged violations of the Unfair Trade Practice Act. §§ 375.930-375.948. The Director is tasked with protecting Missouri consumers and with enforcing the Unfair Trade Practice Act, including its broader definitions of deceptive marketing materials in 20 CSR 400-5.700. The Director's Order addressed the Company's claim of truth in ¶s 31 and 61, concluding that the Company's marketing material violated "§ 375.934 by engaging in unfair trade practices as defined in § 375.936(6), by committing the violations defined in § 375.936(6) with such frequency to indicate a general business practice to engage in that type of conduct." The misrepresentation and false advertising violations defined in § 375.936(6) are further defined by rule in 20 CSR 400-5.700(4)(B) which prohibits advertisements that are misleading in fact or *implication*. (Emphasis added). Further 20 CSR 400-5.700(5)(A)1. prohibits benefit advertisements that:

> [O]mit information or use words, phrases, statements, references or illustrations if the omission of this information or use of these words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable.

The Director addressed the Company's proposed finding of fact by concluding that the words "actual charge" were deceptive and had the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers. The Director explicitly listed as a fact that the statements in the Company's marketing materials that these limited benefit cancer policies pay "regardless" or "in addition to" other insurance or Medicare are not literally true. Order, A-6, ¶ 31. "Regardless" is defined by Webster's Third New International Dictionary to mean "without taking into account." Disregarding these marketing materials, the Company did take into account other insurance or Medicare when it paid lesser benefits to policyholders who had other insurance or Medicare based upon the discounted rates accepted by medical care providers. Tr. 104. The Company also paid lower benefits to policyholders with major medical insurance than it paid to policyholders with no major medical insurance. Tr. 104-105.

¶ 22: The Company alleged that statements in marketing materials that it paid benefits "direct to the insured" are literally true and were not disputed at the hearing. Further, the issue was not material to the case or issues pending before the Director or to his decision.

¶s 23, 27, 28, 33, 34, 35 and 36: These proposed findings by the Company relate to the evolution in medical billing practices. The Director addressed the evolution in billing practices in ¶s 17, 19 (which specifically addressed the Company's proposed fact ¶ 23), and 22 of the Order.

¶s 29-31, 41 & 42: While Mark Chapman's and Lee Ann Blakey's status as experts was not explicitly included as findings of fact in the Director's order, Mr. Chapman's and Ms. Blakey's testimony regarding the evolution in medical billing practices was addressed by the Director in ¶ 17 of the Order (also addressing the Company's proposed facts ¶s 41 and 42). Furthermore, their status as experts would not control the decision, as the Order specifically found that while the Company explained the reason for its change in its administration of actual charges policies, their testimony did not have probative value on the ultimate issue: the Company unilaterally and without consideration reduced the amounts paid to its cancer-stricken policyholders. Order, A-4, ¶ 22.

¶ 32: This paragraph addresses the Division's lack of rebuttal to the Company's expert testimony which was addressed by the Director in ¶ 19 of the Order.

¶ 37: The Company seeks a finding of fact that the Report states the actual charge change resulted in more consumer complaints, and a Company witness testified it received one more complaint. However, this proposed fact ignores the language of the Report which indicated the Company *and* the Department received consumer complaints because of the change. Report, A-24. Additionally, the Company fails to explain in its brief how its proposed ¶ 37 "may control the decision." 20 CSR 800-1.100(7)(A).

¶s 38, 39, 61, and 62: These proposed findings by the Company attempt to explain or justify the Company's changed benefit payment practices, not the fact that the Company unilaterally, and without prior notification, attempted to modify in-force, guaranteed renewable policies as addressed in the Order at ¶ 22.

¶s 40 and 57: The Company's proposed facts regarding Medical billing limitations and variances were addressed by the Director in ¶s 17 and 19 of the Order.

¶s 43, 48-53: The prior Department statements asserted by the Company were specifically addressed by the Director in ¶s 39 – 42 and 70-73 of the Order. Further, the Director addressed these proposed facts in the Order by highlighting the fact that the Company's illegal actions took place "nine months **before** the earliest correspondence" with Department personnel. Order, A-14, ¶ 72 (emphasis in original).

¶ 45: The Company's consumer complaint log was addressed by the Director in ¶ 37 of the Order.

¶ 46: The lack of litigation in the state of Missouri involving actual charge benefits was of no consequence to the issues involved in this case and had no impact on the Director's Order.

¶ 58: This proposed fact, that claims processing is manual, is irrelevant. The Company is obligated to comply with Missouri law in the timeliness of processing claims. Furthermore, benefit payment processes and the timeliness of those benefit payments were addressed by the Director in ¶s 33 – 35, 65 and 66 of the Order. Significantly, neither before the Director nor on this appeal does the Company challenge the violations found regarding timeliness in claim practices. *See, e.g.*, Order, A-6, ¶ 33.

¶s 59 and 60 concerning the *Skelton* litigation were addressed and rejected by the Director in ¶s 74 – 78 of the Order. Also, the Company's proposed fact ¶ 60 is statement of law regarding who is bound by the *Skelton* litigation.

The foregoing readily demonstrates that the Director issued findings of fact responsive to the Company's proposed findings that may have controlled the decision. This is not a situation where an agency failed to provide findings of fact for this Court's review. Rather, the Director made unequivocal, affirmative findings of fact that can be examined by this Court to determine if any of the statutory reasons for review listed in § 536.140.2 merit affirmance, reversal, or modification of the Director's Order. *See* § 536.140.5. Further, the Company has failed to demonstrate prejudice or that the fairness or correctness of the proceedings was impaired by the Director's alleged failure to explicitly rule on the Company's proposed factual findings.

Finally, the record before this Court contains the Department hearing transcript and all exhibits admitted at the Department hearing and considered by the Director before he issued his Order accepting the Report for filing. The voluminous record is sufficient to determine whether or not the Director's decision warrants reversal under any of the grounds listed in § 536.140.2. A remand for explicit rulings upon the Company's proposals would be useless because this Court has sufficient information in the Director's Order and record to conduct judicial review of the administrative decision. "[T]he law does not contemplate a useless act." *State ex rel. Mills v. Allen,* 344 Mo. 743, 755, 128 S.W.2d 1040, 1046 (Mo. banc 1939).

B. The Director did not declare the meaning of the term "actual charge" and therefore the Company's point asserts no reviewable error that the Director's Order is in violation of constitutional provisions or in excess of the Director's statutory authority or jurisdiction, in that the Director merely accepted for filing Final Market Conduct Examination Report.

The Company's second point proceeds from a faulty premise. The Company's primary contention here is that the Director exceeded his authority and jurisdiction by declaring the meaning of "actual charge" in his Order contrary to Missouri law and 20 CSR 400-2.065(3) by "approving the Final Examination Report in full." Company Brief, p. 20. This contention is disingenuous. The Director did *not* declare the meaning of "actual charge": the Director's Order merely accepted the Report for filing. Order, A-18. The Director did not enter a finding of fact or issue a conclusion of law declaring the meaning of the term "actual charge". Order, A-1-18.

The Company next expends several pages of tangent analysis to convince this Court that it is the Director's fault the Company's policies are ambiguous: "[A]ll of the policies and endorsements attacked by the Director in this proceeding were and are on file and approved by the Director, which indicates as a matter of law they were not ambiguous." Company Brief, p. 21. This strained analysis fails for three reasons.

First, the Company's argument is actually an estoppel argument. As addressed more thoroughly in Point H, *infra*, estoppel will not lie against the Director in this matter as the Company cannot satisfy the elements of estoppel against the government. Second, the Company asserts that the Director's approval of any insurance policy form renders the policy unambiguous "as a matter of law." Company Brief, p. 21. If this assertion is true, Missouri case law would not be replete with court decisions addressing questions of insurance policy ambiguity. That the Director, in approving policy forms, is unable to imagine every species of monetarily-induced creativity does not render the later demonstrated ambiguity acceptable. Third, the Company

changed its policy administration regarding payment for actual charge benefits by requiring proof of payments accepted by the provider, rather than allowing whatever the policyholder submitted to the Company for the payment of their claims as it had done for years. Tr. 49, 53, 220-221. The Company's behavior revealed the ambiguity regarding its policies, not the Director. This will be discussed in greater detail in Point E, *infra.*

Lastly in this point, the Company argues that because the term "actual payment" is defined in 20 CSR 400-2.065(1), the Director should have used this regulation to resolve the ambiguity of the term "actual charge." Again, because the Director did not declare a meaning for the term, this point of error is without foundation. As correctly concluded by the Director, the phrase "actual payment" is not at issue in this matter; that the word "actual" appears in the phrase does not render the phrase sufficiently similar to the term "actual charge" to provide any guidance. Order, A-17, ¶ 82.

For these reasons, the Company's second point presents no reviewable error for this Court to consider and should be disregarded.

C. The Director did not err in entering his Final Order because the Director is not bound by the Alabama class action in that he was not a party to that proceeding, the Alabama court did not in that proceeding exercise jurisdiction over the Director or the subject matter of this proceeding, and the Director has not entered an Order imposing relief inconsistent with the Alabama class action order.

The Company claims that a judgment entered in an Alabama class action, *Skelton v. Central United Life Ins. Co.*, CV-2008-900178, final on January 20, 2009, precludes the Director from enforcing Missouri insurance laws against the Company. The Company's argument that "full faith and credit" applies in this matter, and precludes the Department's enforcement actions against it is utterly without merit. The full faith and credit clause of the United States Constitution, or as codified in Missouri under § 490.130, RSMo, has no application to this proceeding.

"Missouri courts give full faith and credit to judgments of sister states except where it can be shown that no jurisdiction exists over the subject matter or over the person or where the judgment was obtained by fraud." *Miller v. Dean*, 289 S.W.3d 620, 624 (Mo. App. W.D. 2009); *see also Phillips v. Fallen*, 6 S.W.3d 862, 864 (Mo. banc 1999). A judgment is not entitled to full faith and credit where the sister state lacked jurisdiction over the party. *Byers v. Auto-Owners Ins. Co.*, 119 S.W.3d 659, 670 (Mo. App. S.D. 2003).

The Director was not a party to the Alabama state court case, that court did not purport to exercise jurisdiction over the Director, and the Company does not contend otherwise. The Alabama state court has no jurisdiction to decide how the Director should apply Missouri insurance laws to the Company's conduct in the state of Missouri. Nowhere in the *Skelton* Final Judgment, upon which the Company relies, does the Alabama court attempt to extend subject matter jurisdiction over the regulatory authority of the Director. Ex. 20(C). The Alabama court

lacks jurisdiction over the enforcement of Missouri's insurance laws against an insurer licensed and doing business in Missouri.

Given the applicable law, the Company has no basis to assert that the Director erred in entering his Order because it violates the full faith and credit clause. It is, however, possible that the Company misunderstands the two-step process involved here, in that the Company purportedly challenges "the Director's instruction that Central United 'should re-process, and pay, based on the provider's bill charge, all claims filed on all such policies issued before October 16, 2001, for which benefits were payable on the provider's *actual charge*.'" Company Brief, pp. 30-31 (emphasis in original). While that quoted language is contained in the Report that the Director's Order accepted for filing, the Director has issued no such instructions to the Company nor has he imposed a remedy on the Company. The only issue that came before the Director below was a request to modify the Report's findings as allowed by 20 CSR 100-8.018(1)(F). SROR 1. If the examination report reveals that the company is operating in violation of any law or regulation and upon accepting the examination report as filed, the Director has three options: (1) he may issue a confidential internal order for any legal or regulatory action (which is what the Director did here); (2) he may reject the examination report; or (3) he may order an investigatory hearing. *See* 20 CSR 100-8.018(1)(G)1, 2, & 3. The Director has imposed no remedy in this proceeding that fails to give full faith and credit to the Alabama court decision.[8] In entering his Order accepting the Report for filing, the Director did not violate the full faith and credit clause merely because that Report requested a type of relief that has yet to be considered. No grounds under § 536.140.2 support reversal on this point.

[8] If this Court affirms the Director's Order accepting the Report as filed, the Director, exercising his regulatory authority, may then enter an appropriate order pursuant to § 374.205.3(3)(a) RSMo 2000.

D. The Director did not err in entering his Final Order because § 376.789 RSMo (Supp. 2009) was not effective until after the issuance of the Final Order and giving it effect in this proceeding would violate the Missouri Constitution in that to do so would constitute an impermissible ex post facto law, retrospective operation of law, and impairment of the obligation of contracts.

The Company seeks this Court to reverse the Director's Order by claiming that § 376.789 RSMo (Supp. 2009), which defines "actual charge" and prohibits insurers from paying policyholders an amount in excess of that definition, applies to the policies at issue in this action. The Company's point is without merit.

1. Ex post facto, retrospective, and contract impairing laws.

"The rules of construction demand that this Court 'adopt any reasonable reading of the statute that will allow its validity and ... resolve any doubts in favor of constitutionality.'" *State v. Ellison*, 239 S.W.3d 603, 606 (Mo. banc 2007), quoting *State v. Burns*, 978 S.W.2d 759, 760 (Mo. banc 1998). Because the Missouri Constitution prohibits ex post facto laws, laws retrospective in operation, and those that impair the obligation of contracts, § 376.789 (effective August 28, 2009) – which defines "actual charge" and prohibits payments in excess of "actual charges" in certain circumstances – should be construed to apply only to contracts entered into or initiated after its effective date. The Company's arguments concerning § 376.789 and its application to the policies at issue in this case – which predate the statute – should be disregarded by the Court.

Article I, § 13 of the Missouri Constitution prohibits any law that is "retrospective in its operation." "Because retrospective laws are barred, the Court presumes that statutes operate prospectively unless legislative intent for retrospective application is clear from the statute's language or by necessary and unavoidable implication." *State ex rel. Schottel v. Harman*, 208 S.W.3d 889, 892 (Mo. banc 2006). "Retrospective laws are generally defined as laws which

'take away or impair rights acquired under existing laws, or create a new obligation, impose a new duty, or attach a new disability in respect to transactions or considerations already past.'" *Doe v. Roman Catholic Diocese of Jefferson City*, 862 S.W.2d 338, 340 (Mo. banc 1993) (internal citations omitted). "[T]he bar against retrospective legislation has traditionally been applied only to substantive laws." *Id.* at 341. "Generally, substantive laws are those that relate to the rights and duties giving rise to a cause of action; procedural laws relate to the machinery for processing the cause of action." *Id.* (internal citations omitted). A retrospective law is one that "give[s] to something already done a different effect from that which it had when it transpired." *Schottel*, 208 S.W.3d at 892. Here, Company seeks to give to its previously-entered contracts a different effect from that which the contracts had when they were agreed to by the parties.

The Fourth Circuit Court of Appeals recently considered the issue of statutory retroactivity in a strikingly similar situation. In *Ward v. Dixie Nat'l Life Ins. Co.*, 595 F.3d 164 (4th Cir. 2010) (affirming appeal after remand), the plaintiffs purchased cancer insurance policies that provided actual charge benefits similar, if not identical, to the policies at issue in this litigation. The plaintiffs sued the insurance companies for breach of contract when the insurance companies changed the way they administered actual charge benefits and began paying claims based on the amount health care providers accepted as payment in full. *Id.* at 169. Earlier, the insurance companies had paid actual charge claims based on the amount the health care provider charged for its services instead of the lower contractual amount it agreed to accept from certain health carriers. *Id.* at 170. The holding in *Ward* centered on the meaning of "actual charges." Plaintiffs contended, as does the Division in this action, that the phrase meant "the full amount a medical provider billed patients for its services," while the insurance companies contended, as

does the Company in this action, that the phrase meant "the lesser amount a medical provider received as payment from insurers for its services." *Id.* at 169-170. While the *Ward* litigation was pending, the South Carolina state legislature enacted a statute defining "actual charges" in a manner identical to §376.789. *Id.* at 171. South Carolina, like Missouri, has a presumption against statutory retroactivity, though an exception exists in South Carolina when there is express legislative intent for the statute to apply retroactively or to lawsuits already initiated. *Id.* at 172. Ultimately, the Court of Appeals in *Ward* held that the South Carolina statute defining "actual charges" could not be interpreted to apply to the policies at issue because: 1) the legislature failed to express an intent that the statute apply to lawsuits initiated prior to the statute's effective date; 2) existing policyholder's rights would be substantively impacted by the intervening legislation; and 3) the statutory language did not show explicit legislative intent to apply retroactively. *Id.* at 172.

2. Prohibition of retroactive laws impacting substantive rights.

In Missouri, the State Constitution prohibits retroactive laws impacting substantive rights. "[S]ubstantive law creates, defines and regulates rights." *State v. Jaco*, 156 S.W.3d 775, 781 (Mo. banc 2005). Section 376.789 impacts substantive rights because policyholders' interests in collecting policy benefits based on the amount charged by health care providers would be adversely impacted if § 376.789 were applied to their policies. If applied to the policies at issue in this case, § 376.789 – which includes language identical to the South Carolina statute at issue in *Ward* – will prohibit the Company from paying actual charge claims in excess of the amount accepted as payment in full by a health care provider regardless of the intent of the parties to the insurance contract. If § 376.789 is not applied to the policies at issue in this case, policyholders who have not settled their claims with the Company may collect actual charge benefits based on

the language of the in-force policy – language that is ambiguous and must be construed in favor of the policyholder.[9] *Jones v. Mid-Century Ins. Co.*, 287 S.W.3d 687, 690 (Mo. banc 2009). It is undisputed that at least four Missouri policyholders opted out of the *Skelton* settlement Ex. 20(MM p. 4). Thus, to meet the presumption of constitutionality, § 376.789 must apply prospectively only and not apply to the policies at issue in this case.

Section 376.789 also impacts substantive rights in that it affects a policyholder's right to collect actual charge benefits as reflected in the policy language – language that has been in effect since the policyholders began paying premiums years ago and before the Company changed how it administered actual charge benefits. Section 376.789 defines "actual charge" or "actual fee" for policies that contain those terms but includes no definition, consistent with the interpretation of "actual charge" advocated by the Company during the Market Conduct Examination process and in this litigation. The "actual charge" policy language at issue in this litigation is directly impacted by § 376.789. After August 28, 2009, § 376.789.2 prohibits the Company from paying "a claim of benefit under the applicable policy in an amount in excess of the actual charge or actual fee as defined in this section." If the § 376.789.2 prohibition is applied to policies issued before August 29, 2009, those policyholders' substantive rights to collect actual charge benefit payments will be significantly impaired. Because the term "actual charge" is undefined in the policies at issue in this litigation, and because the term is ambiguous, policyholders are entitled to collect actual charge benefit payments based on an interpretation that is most favorable to the insured. *Jones,* 287 S.W.3d at 690. Hence, retrospective application of §376.789 would deprive policyholders of that right.

[9] A court construing the policy language in a manner most favorable to the policyholder would likely result in the policyholder being entitled to the higher amount billed for health care services without any reduction based upon the amount the health care provider accepted as payment in full. *See, e.g., Pierce v. Central United Life Ins. Co.*, 2009 WL 2132690 at *9 (D. Ariz., July 15, 2009).

A statute is presumed constitutional. If § 376.789 applied retrospectively, it would impair policyholders' substantive rights. Therefore, to be constitutional, § 376.789 must be interpreted to apply prospectively only and not to the policies at issue in this case. The Company's arguments concerning § 376.789 should be rejected.

E. The Director did not err in accepting, as filed, the Final Market Conduct Examination Report which found that the Company violated § 376.780 RSMo 2000 because the substantial and competent evidence upon the whole record supports the Director's Order which is not arbitrary, capricious or unreasonable in that the Company changed its policy administration regarding payment for actual charges unilaterally and without prior notification or agreed upon consideration.

The Director properly concluded that the Company failed to meet its burden that the Report should be modified or rejected regarding the finding that the Company violated § 376.780 by delivering insurance policies not in conformity with § 376.777.7(3) (prohibiting ambiguities in policies), and that the Company failed to interpret the term actual charges in the manner most favorable to the insured. Order, A-11, ¶ 58. To reach this conclusion, the Director exercised his discretion on the factual questions and evidence before him, and this Court cannot substitute its discretion for that of the Director. *Angelo v. State Bd. of Registration for the Healing Arts*, 90 S.W.3d 189, 191 (Mo. App. S.D. 2002). "The fact-finding function rests with the [agency] and even if the evidence would support either of two findings, the court is bound by the [agency's] factual determination." *Harrington v. Smarr*, 844 S.W.2d 16, 18 (Mo. App. W.D. 1992).

1. Facts supporting the Director's Order.

The Director's Order is supported by competent and substantial evidence upon the whole record. Until February 2003, the Company advertised, marketed, and administered its policies such that it paid claims received in accordance with the health care providers' billed charges. Tr. 49, 221. Beginning in February 2003, the Company decided to pay claims pursuant to negotiated discounts based on evidences of benefit received – EOBs, Medicare Summary Statements, etc. Tr. 53, 161. This change in the way the Company administered its claims was not communicated in or consistent with its advertisements, marketing, or communications to its insurance agents and policyholders until at least July 2003. Tr. 60; Report, A-26. It was not until October 2003, that the Company attempted to change without agreed upon consideration

the language of the existing Company policies and newly issued policies by issuing an endorsement containing a definition of "actual charge". Tr. 192; Ex. 20(1 and 3). The policies were guaranteed renewable, Tr. 39, and the Company had no right to modify these contracts without mutual consent or consideration. Finally, in December 2003, almost a year after the Company decided to change its claims handling practices, it began using and marketing a new policy form which contained a definition for "actual charges." Tr. 101-102.

By changing the way the Company administered its claims, it changed its application of "actual charges" from the way it had been using that phrase prior to February 2003 – that is, the amount the provider billed or list price – to something different. "Actual charge" benefit payments were now based on the providers' negotiated discounts. Tr. 104. Only after the Company decided to limit its benefit payments did it feel the need to explain and subsequently define how it was going to administer claims based on "actual charges." Tr. 45. The Company's action created ambiguity in its policies since the term "actual charges" was now susceptible to more than one meaning. The Company first tried to reconcile this ambiguity in October 2003 with an endorsement and then the Company revised its policies in December 2003 to define what it meant by "actual charges." Tr. 192. Prior to that date, however, the Company's products, and those for which it had liability, were sold, marketed, and administered in a manner that was inconsistent with its new administration practices.

2. The policy term "actual charge" is ambiguous.

An ambiguity exists when there is uncertainty in the meaning of a term or terms in an insurance policy. *Christensen v. Farmers Ins. Co., Inc.*, 2010 WL 363445 at *2 (Mo. App. E.D., February 2, 2010), citing *Jones v. Mid-Century Ins. Co.*, 287 S.W.3d 687, 690 (Mo. banc 2009). If language is "reasonably open to different constructions," then it is considered ambiguous.

Jones, 287 S.W.3d at 690. Courts consider the language in the policy "in light of the meaning that would normally be understood by the layperson who bought and paid for the policy" and by reading the policy in its totality. *Id.* The Division interpreted that phrase to mean "what the provider would charge the patient absent of any other coverage . . . . what the provider would have billed the individual." Tr. 141-142; Report, A-31. This happens to be consistent with the "actual charge" definition in Mosby's Medical, Nursing & Allied Health Dictionary: "the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for services by an insurance plan." MOSBY'S MEDICAL, NURSING & ALLIED HEALTH DICTIONARY 26 (4th ed. 1994). Because the phrase "actual charge" was not defined in the policy, it is reasonable for a policyholder to believe that actual charges would be what the doctor billed or charged for the services rendered. Tr. 188. This understanding is particularly comprehensible in light of the Company's marketing materials.

Section 376.777.7(3) prohibits ambiguities in individual health insurance policies. As such, the Company was under an obligation to interpret the undefined phrase "actual charges" in the manner most favorable to the insured. *Jones*, 287 S.W.3d at 690. This the Company clearly did not do. By adopting and implementing the less favorable interpretation and claim administration procedures for those policies where that phrase was undefined, the Company also violated § 376.780 by delivering policies not in conformance with § 376.777.7(3).

The Company highlighted the term's ambiguity during the hearing when it extracted painfully confusing testimony from Division examiner Jim Mealer, Tr. 141-146, and discussed thesaurus alternatives for the individual words "actual" and "charge". Tr. 145. Such logic was rejected by the federal court in *Ward v. Dixie Nat'l Life Ins. Co.*, 257 Fed. Appx. 620, 625 (4th Cir. 2007), *cert. denied*, 129 S.Ct. 82 (2008), *after remand*, 595 F.3d 164, 171 (4th Cir. 2010).

In a case with facts almost identical to this one, a federal district court concluded "that the term 'actual charges' is ambiguous," in that it "can be reasonably construed to mean the amount set forth on the statement sent by the medical provider to the patient ... the amount the patient was originally billed for the medical services, even if the medical provider is required to accept less from the patient's insurance carrier." *Pedicini v. Life Ins. Co. of Ala.*, 2010 WL 583683 at *4 (W.D.Ky., Feb. 16, 2010). That case also cited several other courts that have "likewise concluded that the term 'actual charges' in supplemental insurance policies," like the ones at issue in this matter, is ambiguous. *See also Ward,* 257 Fed. Appx. at 625 (holding that an interpretation of the phrase actual charges was "not the only one possible when the language of the policy is considered in light of its context"), *after remand*, 595 F.3d 164, 171 (4th Cir. 2010) (reaffirming its previous opinion that the phrase "actual charges" "was patently ambiguous"); *Pierce v. Central United Life Ins. Co.*, 2009 WL 2132690 at *9 (D. Ariz., July 15, 2009) (interim order concluding that because the phrase can have multiple meanings, it is ambiguous, and the policy should be construed in favor of the insured).

In *Pierce*, the plaintiff, a former insurance agent for Dixie National Life Insurance Company,[10] purchased a Dixie supplemental cancer insurance policy in 1991. The policy marketing materials state that the policy would pay "100% of the actual charges" for radiation therapy and air transportation to obtain cancer treatment. *Pierce* at * 1. In 1994, the Company assumed all of Dixie's contractual liabilities, including Pierce's supplemental cancer insurance policy. *Id.* In February 2003, the Company changed the way it administered "actual charges" benefits to pay "actual charges" benefits based on the amount paid by the policyholder and/or the their primary insurance provider in satisfaction of the health care provider's bill. *Id.* at * 2. In

[10] Significantly, the Company acquired the Dixie National Life Insurance Company cancer policies in 1997, Company Brief, p. 7, ¶ 7 & 8, and administers that block of business. Order, A-3, ¶ 13; Tr. 36, 220.

October 2003, Pierce was diagnosed with cancer and received cancer treatment until February 2004. *Id.* Pierce submitted claims to the Company under his Dixie policy and was paid an amount less than he expected based on his experience selling the Dixie policies and Dixie's and the Company's prior administration of the policies. *Id.* Pierce sued the Company for the difference in what he understood "actual charges" to mean and the reduced amount the Company paid him based on the Company's changed benefit administration.

The policy form in *Pierce*, CP-1004 (which was issued by Dixie and administered by the Company), is one of the very same policies at issue in this litigation. Ex. 20(5). Thus, the issue in *Pierce*, the interpretation of "actual charges," is identical to the issue presented in the current litigation. The *Pierce* court determined that "actual charges" with regard to Form CP-1004 "is reasonably defined as the amount billed by the health care provider, before any insurance adjustments that may reduce the amount that the health care provider accepts as payment in full." *Id.* at * 9.

Furthermore, consistent with *Pierce*, Mosby's Medical, Nursing & Allied Health Dictionary defines "actual charge" as "the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for services by an insurance plan." MOSBY'S at 26. "Actual charge" could reasonably refer to the amount the medical provider billed the insured. *Pierce*, 2009 WL 213690 at *6. The Company even used this definition prior to February 2003 by accepting whatever paperwork the policyholder received from the provider. Tr. 49. It decided to change how it administered claims in February 2003 and include a written definition of the phrase in a policy endorsement it began to use in October 2003. "When the drafter of such a contract leaves an important term undefined, public policy deems that the consequences of the imprecise drafting should fall on the party that drafted

the contract." *Pierce*, 2009 WL 213690 at *8, citing *Bjornstad v. Senior Am. Life Ins. Co.*, 599 F.Supp.2d 1165, 1172 (D. Ariz. 2009). The Company failed to prove that its definition of "actual charge" was not ambiguous and the Director properly accepted the Report as filed.

The Company points this Court to the testimony of its witnesses regarding the Company's and industry's payment practices to support its contention that there was no change in the definition of actual charges by the Company. However, as correctly found by the Director, although the Company's evidence:

> explains perhaps **why** it instituted the change, the extensive evidence of Central United regarding the gradual evolution of medical billing and reimbursement is immaterial and irrelevant to the ultimate issue in the Final Report: Central United unilaterally, and without prior notification, attempted to modify in-force, guaranteed renewable policies.

Order, A-4, ¶ 22 (emphasis in original).

As demonstrated above, the Director's Order accepting the Report as filed is supported by competent and substantial evidence upon the whole record and is not arbitrary, capricious or unreasonable. Therefore, the Director's Order must be affirmed.

F. The Director did not err in issuing his Conclusions of Law because the Conclusions properly found violations by the Company of Missouri's insurance laws in that the Conclusions identify each violation by the Company, are not legally erroneous, and are supported by competent and substantial evidence upon the whole record.

The Company outlines its allegations of error to selected Conclusions of Law in the Director's Order using one phrase assertions with limited analysis.[11] For the reasons set forth below, the Company has failed to carry its burden of persuasion before this Court to show why the Director's Conclusions of Law finding numerous violations of Missouri's insurance laws by the Company should be reversed.

1. Conclusions of Law ¶s 55 and 56

The Director found that, as a matter of law, based upon substantial and competent evidence, the Company engaged in a general business practice of unilaterally, without the policyholders' consent or an exchange of consideration, imposing a new contractual term and changing its claims administration for actual charge policies. This conduct was fraudulent, amounted to a failure to carry out its contracts in good faith, and compelled policyholder-claimants to accept less than the amount due under the terms of their policy which violated §§ 375.445 and 375.936(13).[12]

Without the policyholders' consent and new consideration offered, this change to the existing Company policies was ineffective. "Parties who make a contract have the power to modify it by a subsequent agreement, but there must be a sufficient consideration for the modification to give it contractual force." *Wilt v. Hammond,* 165 S.W. 362, 364 (Mo. App. S.D. 1914), quoting *Patterson v. Insurance Co.*, 148 S.W. 448, 450 (Mo. App. W.D. 1912) (involving

[11] The Company does not challenge as erroneous the following Conclusions of Law: ¶s 43-53, 65-69.

[12] The Company curiously claims that there was no express finding of a violation of § 375.934. However, ¶ 55 contains such an express finding.

a fire insurance policy).

The Company argues because that the procedures in § 375.445 for finding a violation were not followed so the conclusions must be reversed. The Company, however, fails to recall that the violation was found in the course of a market conduct examination pursuant to particularized procedures under § 374.205, and that it did indeed receive a hearing at its request. Next, the Company again relies on its estoppel-type argument that the policy form was approved by the Director so there can be no violation. Estoppel can only run against the government "where there are exceptional circumstances and a manifest injustice will result." *Gosal v. City of Sedalia*, 291 S.W.3d 822, 828 (Mo. App. W.D. 2009). *See* Point H, *infra*, for further discussion of the standard. Finally, the Company inappropriately points to *Skelton*, the Alabama class action addressed by the Director in Point C, *supra*, as a basis to avoid the violations. The judgment in *Skelton* became final in 2009, but the market conduct examination reviewed the Company's conduct for the period of 2002 through 2004.

2. Conclusions of Law ¶s 57, 58, 63, and 64

The Director concluded that the Company violated § 376.780 by delivering policies which were ambiguous and, therefore, not in conformance with § 376.777.7(3). This ambiguity is demonstrated by the Company's claim that its policies supposedly allowed claims to be paid in at least two different ways, one of which resulted in lower payments to policyholders. In response, the Company restates, in a somewhat condensed form, some of its arguments presented in Point E. For the reasons stated in Point E, *supra,* the Director did not err in issuing these conclusions of law. The Director incorporates and asserts his response in Point E as if fully set forth herein. The Company also urges the Court to reverse these conclusions as erroneous because they ignore the definition of "actual payment" in 20 CSR 400-2.065(1) (addressed by

the Director in Point C, *supra*) and new § 376.789 defining the phrase "actual charge" (addressed by the Director in Point D, *supra*). These findings are not legally erroneous.

3. Conclusions of Law ¶s 59, 60, 61, and 62

In these Conclusions, the Director held that the Company's failure to disclose that the policyholders' actual charges benefits were affected by "other insurance" made the Company's marketing and advertising of its policy forms incomplete, deceptive, ambiguous and a misrepresentation of the benefits, advantages, conditions, or terms of the policies, in violation of § 375.936(6) and 20 CSR 400-5.700(4) and (5)(A)1. This unlawful conduct constituted an unfair trade practice under § 375.934. This same conduct, committed with such frequency to indicate a general business practice, also violated § 375.445 (which is a *per se* violation of § 375.936(13)). The Director's analysis in Point E addresses the factual predicate of these violations.

The evidence presented at the hearing, including the Report and its accompanying workpapers, established the following regarding the Company's sales, advertising, and underwriting practices: 1) that many of the Company's marketing materials used in the sale or solicitation of its policies that paid benefits based on the health care providers "actual charge" never defined or explained that phrase; 2) that after February 1, 2003, the Company changed its claims administration practices to pay claims based on the amount the provider agreed to accept from the policyholder's primary health plan; 3) that no notice was sent to the Company's sales agents informing them of this change until July 2003; 4) that none of the advertising materials used by the Company either before or for a lengthy period after February 1, 2003, defined or adequately disclosed to potential customers what the phrase "actual charges" really meant, and how the Company would interpret it; 5) that many of the advertisements overemphasized the benefits of the policies without also giving proper prominence to the exclusions and limitations

and contained misleading or deceptive language; 6) that after February 2003, the Company reinterpreted the policy term "actual charges" to mean the amount the provider accepted from the policyholder's primary insurer (i.e., the negotiated discount from billed charges) and began administering claims consistent with that reinterpretation; 7) that the Company failed to disclose that the policyholder's actual charges benefits were affected by "other insurance, so therefore, its marketing and advertisements were incomplete, deceptive, ambiguous and a misrepresentation of the benefits, advantages, conditions or terms of policies, and 8) that the Company's assumption of the business of Dixie and Commonwealth does not excuse the Company's liability for the unlawful conduct related to the sale and marketing, and or related to the administration of claims for the block of policies acquired from Commonwealth and Dixie. Report, A-20-39.

The Director properly found that the Company's marketing was ambiguous and misrepresented the benefits, advantages, conditions, or terms of the policies, in violation of § 375.936(6) and 20 CSR 400-5.700(5)(A)1. In addition, § 375.936(3) prohibits the misrepresentation and false advertising of insurance policies and their benefits, and 20 CSR 400-5.700(4) requires that the form and content of the advertisements "be sufficiently complete and clear to avoid deception." By using language that is nonspecific, ambiguous, and uncertain, consumers were not adequately informed as to the exact scope of their coverage. These acts and omissions failed to fully inform the Company's current and potential customers of the effect of "other coverage" on the level of payment provided by the Company.

The Director, relying upon the substantial and competent evidence in the record, properly applied Missouri insurance laws to conclude that the Company violated those laws. The Company has failed to demonstrate that any of the Director's Conclusions of Law are contrary to the law or lack evidentiary support and, as such, the Court should affirm the Director's Order.

G. The Director did not err in issuing his Order because the same was issued following a full, fair and impartial contested case hearing in that the Company participated in the delay in the issuance of the Report, the requested continuance was properly denied where the Company received the alternative relief it requested, and where the hearing officer excluded only repetitious testimony and properly questioned the parties' witnesses.

The Company claims, in its title for this Point, that "Bias, conflict of interest and prejudgment of the issues by the hearing officer and the Director invalidate the proceedings under review." Company Brief, p. 46. The Director provided a full, fair, and impartial hearing on August 25, 2009, allowing both the Division and the Company to present evidence regarding the Report. The Director issued his Order on August 27, 2009. Regardless of the short turnaround time between the hearing and the Order, the Company was afforded a full, fair and impartial hearing and the Director's Order should be affirmed.

To prevail, the Company "must overcome a 'presumption of honesty and integrity'" that applies in determining whether the Director's appointed hearing officer afforded the Company sufficient due process during the August 25, 2009 hearing. *Krentz v. Robertson Fire Protection Dist.*, 228 F.3d 897, 905 (8th Cir. 2000), citing *Hortonville Joint Sch. Dist. No. 1 v. Hortonville Educ. Ass'n*, 426 U.S. 482, 497 (1976). A strong presumption exists in favor of the validity of an administrative determination. *Gamble v. Hoffman*, 732 S.W.2d 890, 894 (Mo. banc 1987). The courts "'will not assume that [an] administrative body was improperly influenced absent clear and convincing evidence' to the contrary. *Id.* (citation omitted). The Company faces a heavy burden that it has failed to meet.

1. Timeliness of Report.

The Company asserts that the market conduct examiners and the Director did not comply with the time requirements in § 374.205. An accurate review of the background defeats this

assertion. The Company's market conduct examination began in 2006 and the Director's examiners completed the draft report on August 26, 2008, which was sent to the Company on September 5, 2008. Between September 2008 and summer of 2009, the Company and the Division negotiated changes and clarifications to language of the draft report and continued discussions regarding the meaning of "actual charge" and litigation pending against the Company in other jurisdictions. Twice during this process, the Company requested and received additional time. By participating in lengthy negotiations concerning the content of the draft report and requesting extensions of time during its pendency, the Company invited the very supposed error about which it now complains. '"Invited error' is '[a]n error that a party cannot complain of on appeal because the party, through conduct, encouraged or prompted the trial court to make the erroneous ruling.'" *State ex rel. American Standard Ins. Co. of Wisconsin v. Clark*, 243 S.W.3d 526, 531-32 (Mo. App. W.D. 2008), quoting BLACK'S LAW DICTIONARY 563 (7th ed. 1999). By participating in the delay of the Report's issuance, the Company should not now be heard to complain about this delay.

As heavily as the Company relies on *Skelton,* the Alabama class action, it is surprising that the Company does not recognize the impact of *Skelton* upon the parties' negotiations and, hence, perceived "delay." A month after the Company received the draft report, the *Skelton* court entered its final judgment approving the class settlement on October 9, 2008. Company Brief, p.11, ¶ 21. In its October 31, 2008 response to the draft report, the Company "respectfully suggest[s] that the DIFP consider taking no further action on the issue of payment of actual charges benefits until such time as it is known whether the settlement is finalize or appealed." Ex. 20(MM). The Division honored that request. The parties thereafter continued further discussions toward resolution of the issues until the Report was issued on July 10, 2009.

The Company complains that the Director then failed to take one of four courses of action as required by § 374.205.3(3) within 30 days of the Report and that by failing to take those actions, the Director's Order should be reversed. The Company fails to mention that on August 11, 2009, the Company requested a 30-day extension "to consider the options" in 20 CSR 100-8.018(1)(F). Company Letter, A-40. The Director denied the extension, noting that the Company had requested and received two extensions. Director Letter, A-41. Thereafter, on August 13, 2009, the Company requested a hearing under 20 CSR 100-8.018(1)(F) to modify the Report's findings. SROR 1. Hence, the Company's own action – requesting a hearing – delayed the issuance of a decision regarding the Report. This delay is not something the Company can properly be heard to complain about.

Furthermore, the time limitations about which the Company complains are merely directory. "Missouri courts have sometimes determined that when a statute merely requires certain things to be done and nowhere prescribes the results that shall follow if such things are not done ... the statute is merely directory." *State ex rel. Hunter v. Lippold*, 142 S.W.3d 241, 244 (Mo. App. W.D. 2004).

> The issue of whether a statute is mandatory or directory usually comes up only in the context of whether the failure to do a certain act results in the invalidity of a governmental measure. If such a statute fails to prescribe a result in the event that the act is not performed within the time period, the act is usually directory. In other words, the *failure to timely perform the act does not invalidate the governmental action in question.* However, the fact that the act may be directory does not mean it cannot be compelled by proper legal action.

Id. (emphasis added).

Section 374.205 contains language stating the time limits for filing reports with the Department. *See* § 374.205.3(2). However, because the statute does not "prescribe a result in the event that the act is not performed within the time period," the time limits are directory.

Hunter, 142 S.W.3d at 244. Therefore, the Division's failure to file a verified examination report within the prescribed time does not invalidate the Director's Order.

Additionally, at no time between September 2008 and summer of 2009 did the Company object to the Division's continued negotiations or failure to explicitly comply with the timeline set forth in § 374.205. If the Company desired that the Division file a report in accordance with § 374.205 rather than continue negotiations, the Company was entitled to file a proper legal action to compel the Division to take action. The Company filed no such legal action, and instead continued its participations in negotiations with the Division for approximately nine months. The Company's argument for of reversal should be rejected based upon *American Standard* and *Hunter* and the fact that it waived its opportunity to compel timely action by actively participating in extended negotiations and by its multiple requests for additional time.

2. Denial of requested continuance.

Having just complained about supposedly undue delay, the Company now complains about its absence. The day after the Company requested a hearing under 20 CSR 100-8.018(1)(F), SROR 1, the Director appointed Mary S. Erickson as hearing officer to conduct the hearing as a contested case under 20 CSR 100-8.018.[13] While the hearing was initially scheduled on August 24, 2009, the Company requested a one day continuance and received the requested continuance, with the hearing rescheduled for August 25, 2009. Ex. 4. The Company presented a second request for a continuance to the hearing officer, which was denied for failure to show good and sufficient cause. Ex. 4, 10.[14] The Company renewed its motion for

[13] The Company's footnote 25 notwithstanding, the Company has stipulated that this case is appropriate for contested case review under Article V, § 18 of the Missouri Constitution and §§ 536.100-.140, RSMo. See *Stipulation and Order*, December 21, 2009.

[14] "Central United Life Insurance Co. failed to provide the name of the expert witness, the particular facts the witness will prove or the materiality of such evidence." Ex. 10.

continuance, stating that in the alternative of granting a continuance, the Company requested that it be allowed to offer an affidavit into evidence.[15] Ex. 12. The hearing officer denied the motion for continuance, but granted the Company's request to offer the affidavit into evidence at the hearing. Ex. 17. Therefore, the Company cannot assert error or an abuse of discretion when it received the alternative relief it requested. *State v. Sales*, 58 S.W.3d 554, 560 (Mo. App. W.D. 2001) (no abuse of discretion "where the request was for alternative relief and the judge granted one of the suggested alternatives.").

While the Company could have requested that the Director modify the denial of the requested continuance, 20 CSR 800-1.130(2), it did not do so. "Denial of a request for continuance is seldom reversible error." *Elrod v. Elrod*, 192 S.W.3d 738, 742 (Mo. App. S.D. 2006). In fact, the trial court's action is reviewed for abuse of discretion. *In re D.C.*, 49 S.W.3d 694, 699 (Mo. App. E.D. 2001). The fact that the Company did not even bring to the Director's attention its displeasure with the denial of a continuance is another reason to conclude the Director did not err or abuse his discretion.

3. The hearing officer excluded only unduly repetitious testimony and properly questioned witnesses.

At the August 25, 2009 hearing, the Division and the Company were present and represented by counsel. Both parties presented evidence and had the opportunity to cross examine witnesses. The hearing officer also properly questioned witnesses pursuant to § 374.205.3(4)(b), which provides, "[t]he hearing shall proceed with the director or his or her representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation." The Company cites to no law disallowing a hearing officer from questioning a witness nor did it object to the questioning

[15] "In the alternative, if the Department will allow into evidence an affidavit by Dr. Morrisey that was previously introduced in Skelton v. CULIC, we will proceed using same." Ex. 12.

during the hearing. Even pointed questions to witnesses in an administrative proceeding are not *per se* indicative of bias or prejudice. *Technical & Prof. Servs., Inc. v. Board of Zoning and Adjustment of Jackson Co.*, 558 S.W.2d 798, 803 (Mo. App. W.D. 1977).

The hearing officer fairly overruled Division counsel's objection to the Company's witness testimony regarding market forces and cancer treatment charges. Tr. 56. On several occasions, the hearing officer overruled the Division's objection to a line of questioning directed toward one of the Company's expert witnesses and a document offered by an expert witness. Tr. 122, 125, 126-127, and 132. After several pages of testimony, the hearing officer sustained the Division's objection to the repetitive and cumulative nature of the Company's expert testimony. Hearing officers are statutorily directed: "[U]nduly repetitious evidence shall be excluded." § 536.070(8). Because the Company failed to make an offer of proof as provided for in § 536.070(7), it therefore failed to preserve the issue on appeal. "A litigant who complains about the exclusion of evidence should make an offer of proof to inform the trial court of the content of the proffered evidence and to allow the appellate court to determine the prejudicial effect of the exclusion. The offer must be specific and definite. . . . We will not reverse a judgment without a showing of prejudice." *Pruett v. Pruett*, 280 S.W.3d 749, 751 (Mo. App. S.D. 2009) (citations omitted).

The hearing officer repeatedly (and appropriately) overruled the Division's objections. Tr. 133-134, 135, 140, 152, 172, 178-179, 198-199, 201, 217, 224-225, 227, 239, and 249-250. Though the Company made few objections to the Division's evidence or questions, the hearing officer sustained them as appropriate. Tr. 20-21. The hearing officer conducted an efficient hearing by limiting repetitious or cumulative evidence, particularly uncontroverted evidence regarding changes in the health care market and billing practices, and encouraging the parties to

agree on the admissibility of exhibits. Tr. 108-109. The Director made note of the extensive evidence offered by the Company by including the information in the Order, including citations to the three witnesses and eight exhibits offered by the Company in support of its assertions regarding changes in the health care market and billing practices. Order, A-4, ¶s 17-19.

Based on the above, the Company has not presented clear and convincing evidence to overcome the presumption of honesty and integrity of the hearing office or the presumption of the validity of the Order. The hearing officer provided both parties the opportunity for a full, fair, and impartial hearing. The Company has failed to meet its burden that the Order should be reversed on any ground listed in § 536.140.2.

H. The Director did not err in concluding in his Order that the Company failed to meet the elements of equitable estoppel against the Department because the Company cannot establish that it reasonably relied on Department employees' correspondence, that it was injured by the reliance, or that there was affirmative misconduct by the Department or Director in that the earliest correspondence presented by the Company occurred nine months after the Company changed the administration of actual charge policies.

The Company incorrectly claims that the Director is barred from any relief with respect to the insurance policies at issue in this case because the Director previously approved its claims payment practices. Company Brief, pp. 49-50. It argues that the Director's employees made prior statements that the manner in which the Company was going to process actual charge claims was acceptable. As a result, the Company argues the Director cannot now take action against it to disapprove and assess penalties against it for taking the action that the Department previously approved.

While the Company's recitation of the first three elements of equitable estoppel is correct, Company Brief p. 49, citing *Fraternal Order of Police Lodge #2 v. City of St. Joseph*, 8 S.W.2d 257, 263-264 (Mo. App. W.D. 1999), the Company conveniently fails to add the required element articulated in that case for when estoppel is asserted against the government: "the party must also show that the governmental conduct on which the claim is based constitutes affirmative misconduct." *JGJ Properties, LLC v. City of Ellisville*, 303 S.W.3d 642, 651 (Mo. App. E.D. 2010), citing *Fraternal Order of Police*, 8 S.W.2d at 263. Furthermore, equitable estoppel only runs against the state "where there are exceptional circumstances and a manifest injustice will result." *Gosal v. City of Sedalia*, 291 S.W.3d 822, 828 (Mo. App. W.D. 2009), citing *Missouri Gas Energy v. Public Serv. Comm'n*, 978 S.W.2d 434, 439 (Mo. App. W.D. 1998).

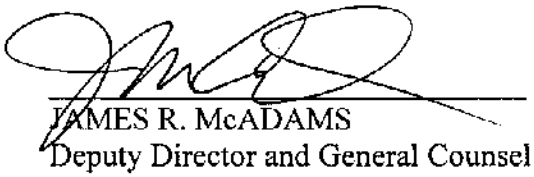
The Company fails to prove that these prerequisites exist. Nothing in the correspondence that the Company presented is a representation or assurance to either the consumer or to the Company upon which they could reasonably rely. This is especially true where the Company decided before February 2003 to change its actual charge claims procedures, nine months before the earliest correspondence between the Company and the Director's employees. Ex. 20(W). The Company could not have been injured by the Director's employees' "assertions" based on the correspondence because it had already changed its procedures and was notifying policyholders before it asked for clarification or "permission" to handle claims in a particular manner. Additionally, the Company can point to nothing in the record to establish the required "affirmative misconduct" by the Director or his employees.

Furthermore, applying estoppels against the Director in this case "will interfere with the proper discharge of governmental duties, curtail the exercise of the state's police power and thwart public policy" of protecting Missouri insurance consumers. *Gosal*, 291 S.W.3d at 828-829. The past knowledge and implicit approval by the Director of an insurance company's business practices do not enjoin the Director from asserting his regulatory authority in the future if, in fact, the practice employed by the company "was unauthorized and unlawful." *Traders Mut. Fire Ins. Co. v. Leggett*, 284 S.W.2d 586, 589 (Mo. banc 1955).

CONCLUSION

Based upon the foregoing, the Company has failed to meet its burden that the Order should be reversed on any ground listed in § 536.140.2 or upon any other ground asserted, and as such, the Director's Order should be affirmed.

Respectfully submitted,



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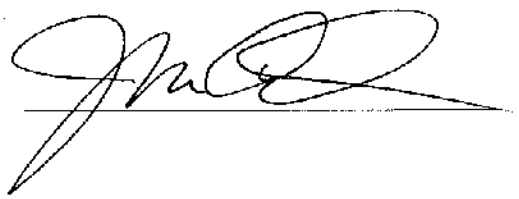
ATTORNEYS FOR DIRECTOR
JOHN M. HUFF

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was mailed, postage prepaid, this 15th day of April, 2010, to:

Sherry L. Doctorian, Esq.
Matthew D. Turner, Esq.
3405 West Truman Boulevard
Jefferson City, Missouri 65109



ADDENDUM

Addendum A-1

State of Missouri

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS & PROFESSIONAL REGISTRATION

IN RE:	)	
	)	
Central United Life Insurance Co.	)	Case No. 090814644C
Missouri Market Conduct Examination	)	
No. 5013-36-TGT	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND CONFIDENTIAL FINAL ORDER ACCEPTING FINAL EXAMINATION REPORT AS FILED

NOW, THEREFORE, Director John M. Huff ("Director") of the Department of Insurance, Financial Institutions and Professional Registration ("Department"), after a hearing, having read the full record, including all the evidence, hereby renders the decision and makes the following findings of fact, conclusions of law and confidential final order in accordance with 20 CSR 100-8.018(1)(G):[1]

FINDINGS OF FACT

A. Procedural History

1. Pursuant to § 374.205.3(2) RSMo 2000, on or about September 5, 2008, the Missouri Department of Insurance, Financial Institutions and Professional Registration ("Department"), Division of Insurance Market Regulation ("Division") mailed to Central United Life Insurance Company ("Central United") a Market Conduct Examination Report of the Cancer and Specified Disease Health Insurance Business of Central United dated August 26, 2008 ("August 26, 2008 Report"). *Central United's Prehearing Proposed Findings of Fact, Conclusions of Law and Order* ("Central United's Prehearing Proposed Order"); *Exhibit MM, October 31, 2009 Central United Response to August 26, 2008 Report.*

2. On October 31, 2008, Central United submitted its formal response to the August 26, 2008 Report in accordance with § 374.205.3(2). *Central United's Prehearing Proposed Order; Exhibit MM.*

[1] Pursuant to 20 CSR 100-8.018(1)(G), the Final Order is a "confidential internal order".

3. In accordance with 20 CSR 100-8.018(1)(E), the Division forwarded to Central United on July 13, 2009 a Market Conduct Final Examination Report ("Final Report") dated July 10, 2009 and signed by Chief Examiner Michael W. Woolbright. The examination report was accompanied by a letter that included a notice to the Company of its rights under 20 CSR 100-8.018(l)(F). *Central United's Prehearing Proposed Order.*

4. The time period covered by the Division's examination of Central United was primarily from January 1, 2002 through December 31, 2004. The stated purpose of the examination was "to determine whether the Company complied with Missouri Laws and [Department] regulations in its marketing, underwriting and administration of cancer and specified disease health insurance policies." *Exhibit 1, Final Report,* p. 4.

5. On August 13, 2009, Central United petitioned the Director of the Department to modify the findings of the Final Report and requested a hearing pursuant to 20 CSR 100-8.010(l)(F). By Notice of Hearing and Order, the Director scheduled the hearing for August 24, 2009, to commence at 1:30 p.m., and designated Mary S. Erickson, Senior Enforcement Counsel, as the hearing officer pursuant to 20 CSR 800-1.130.

6. Upon a request by Central United, the hearing officer rescheduled the hearing for August 25, 2009, to commence at 9:00 a.m., at the Department in Room 530 of the Truman State Office Building, 301 West High Street, Jefferson City, Missouri.

7. At the administrative hearing on August 25, 2009, Carolyn H. Kerr and Kevin Jones, appeared on behalf of the Division. Sherry L. Doctorian of Armstrong Teasdale LLP and Dennis R. Bailey of Rushton, Stakely, Johnston & Garrett, P.A., *pro hac vice,* appeared on behalf of Central United.

8. At the hearing, the Division presented the Final Report into evidence as well as the working papers relating to the market conduct examination. When presenting the Final Report, the Division noted that pursuant to § 375.205, findings of fact and conclusions made pursuant to any examination shall be prima facie evidence.

9. Central United presented five witnesses and documentary evidence in response. The Division presented no rebuttal testimony or evidence. Only Central United chose to make an oral closing argument at the hearing.

B. Parties

10. The Division of Insurance Market Regulation of the Department protects the interests of Missouri's insurance buying consumers by ensuring companies are conducting business in compliance with applicable state statutes and regulations. The Division is authorized to conduct an examination of pursuant to §§ 374.202 to 374.207 of any company engaging in the business of insurance in Missouri.

11. At the time of the examination, Central United was a Texas-domiciled insurer. *Exhibit 1, Final Report.*, p. 1. Since that time, Central United has redomesticated to Arkansas. *Motion to Correct the Record,* p. 1. The correct NAIC Number for Central United is 61883, and

NAIC Group Number is 1117. *Id.* Central United holds a Certificate of Authority to transact insurance business in Missouri. *Exhibit 1*, p. 6.

C. **Findings and Conclusions in Final Report and Evidence**

12. Central United sells and administers supplemental cancer insurance policies which are specific benefit, indemnity policies which pay benefits directly to the policyholder as defined in the policy. *Hearing Transcript ("Tr.")*, 37 – 38 (Central United witness Lee Ann Blakey). Central United's policies are not major medical or health insurance policies. *Id.*

13. In addition to its own policies, Central United administers the closed block of business it acquired from Commonwealth National Life Insurance Company ("Commonwealth") and Dixie National Life Insurance Company. *Tr. 36* (Blakey); *Tr. 220* (John McGettigan); *Exhibit A, Commonwealth Policy Form CEP350REV; Exhibit H, Dixie Advertisement.*

14. The Central United policies at issue provide for three categories of benefits: scheduled, per diem, and actual charge benefits. The third category of benefits provides for a cash payment to the policyholder in the amount of actual charges for chemotherapy or radiation treatment. *Tr. 43 – 45* (Blakey); *see, e.g., Exhibit A, Commonwealth Policy Form CEP350REV and Exhibit B, Commonwealth Policy Form CEP93ULT.* For example, in Exhibit A, page 5, under "Radiation Therapy", the policy states, in part: "We will pay the actual charges for radiation for the purpose of modification or destruction of abnormal tissue."

15. Central United materially changed how it administers the benefit provisions of guaranteed renewable cancer health insurance policies beginning February 1, 2003. *Exhibit 1, Final Report*, p. 5; *Tr. 106* (Blakey). Specifically, the Final Report states:

> Many of the benefit provisions of the Company's cancer policies are worded to pay benefits based on a health care provider's *actual charge* for covered services. Prior to February of 2003, the Company administered those *actual charge* claims based on the amount health care providers billed for their services. Beginning in February of 2003, the Company administered claims based on a different definition of the term *actual charge*. From that date forward, the Company defined *actual charge* to mean, *"...the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided."* As a result, any benefit payments that were based on a provider's *actual charge* were limited to whatever lower amount the provider agreed to accept from the insured person's primary health plan, Medicare or other third party payer.
>
> * * *
>
> The term *actual charge* was not defined in any of the Company's marketing materials or in any of the cancer policies sold in Missouri until October of 2003. It was not until December of 2003 that all cancer policies the company marketed in Missouri that paid one or more benefits based on a health care provider's *actual charge* included a definition of that term.

Exhibit 1, Final Report, p. 5 (italics in original).

16. The Final Report examined the following areas of Central United's operations: Sales and Marketing, Underwriting, Claims, Complaints/Grievances, Criticism & Formal Request Time Study. *Id.*

17. Central United presented extensive (and redundant) evidence regarding the changes in the medical services industry and its billing practices to demonstrate the differential between a provider's "list charge" and the lesser amount accepted by a provider for full payment. *E.g., witnesses Lee Ann Blakey; Mark Chapman; Dr. Michael Morrisey* (by Affidavit, *Exhibit DD*); *Exhibits F, G, Q, R, S, FF, and HH.*

18. Central United ultimately admits that "Central United failed to notice until early 2003" the transformation of the billing practices. *Exhibit MM, October 31, 2009 Central United Response to August 26, 2008 Report; Tr. 107* (Blakey).

19. Central United presented unchallenged evidence that the medical services industry has evolved tremendously since the 1980s. *Central United's Proposed Order,* ¶ 23; *Tr. 48* (Blakey); *Exhibit DD, Affidavit of Michael A. Morrisey, Ph.D.*

20. John McGettigan, Senior Vice President and General Counsel of Central United testified that prior to the February, 2003 change, Central United relied on whatever the policyholders turned in with their claims for the payment of actual charges benefits, such as statements of account, claim forms, computer printouts. *Tr. 221.* Prior to February, 2003, the policyholder would send Central United "whatever document they received from the provider." *Tr. 49* (Blakey).

21. In January, 2003, Central United determined that it "needed to begin asking for EOBs [Explanation of Benefits] from our policyholders so that we could see the amount the providers agreed to accept and were paid in full for the chemo and radiation benefits." *Tr. 220; 223.*

22. Central United failed to present any evidence contradicting or rebutting the fundamental finding of the Final Report: Central United changed its policy administration regarding payment for actual charges benefits by requiring proof of payment accepted by the provider. Although Central United's evidence explains perhaps why it instituted the change, the extensive evidence of Central United regarding the gradual evolution of medical billing and reimbursement is immaterial and irrelevant to the ultimate issue in the Final Report: Central United unilaterally, and without prior notification, attempted to modify in-force, guaranteed renewable policies.

23. In February, 2003, Central United posted on its website a revised claim form and notice to its policyholders advising them of its change in how it was going to administer claims. *Tr. 53* (Blakey); *Exhibit 4, Claim Form.* This notice was also attached to Central United's claim forms beginning in February, 2003. *Id.* As of February 1, 2003, Central United required policyholders to submit as part of their claim "any Explanation of Benefit Statements, Medicare Summary, or statements of account showing the charges paid by you or on your behalf." *Id.* A similar notice was sent to all policyholders and to Central United's producers in July, 2003. *Id.; Exhibits 2 and E, "Important Notice".* The record establishes that while a few policyholders who

filed a claim after February, 2003, used a form with the notice, Central United waited six months before sending notice to all policyholders of its change.

24. The only written communication from the company to its agents regarding this change was sent to them sometime in July 2003. That communication consisted only of a copy of the Notice form that had been sent to the policyholders on July 3, 2003. *Exhibit 1, Final Report, p. 7.* Therefore, between February 1, 2003 and July, 2003, Central United marketed an ambiguously worded policy form, CP3000AMO, through misinformed agents. *Id.; Exhibit 7, Policies.*

25. The term "actual charge" was not explained or defined in any of Central United's Missouri policy forms, advertising or marketing material until October 2003, when Central United attempted to change the language of the existing Central United policies and newly issued policies by issuing an endorsement to the policies which contained a written definition of "actual charge." Endorsement Form CP3ACEND was attached to Policy Form CP3000AMO beginning on or about October 16, 2003. *Exhibit 1, Final Report*, p. 12; *Exhibit 7, Policies.*

26. Central United marketed Policy Form CP3000AMO until December 2003, but never revised the marketing or solicitation materials referencing that policy form to include a written definition of "actual charge" or an explanation of how Central United was administering claims after February 2003. *Exhibit 1, Final Report*, p. 12; *Tr. 102* (Blakey); *Exhibit 3.*

27. No other Central United cancer policies that paid a benefit based on a health care provider's "actual charge" included a written definition of the term "actual charge". *Tr. 45* (Blakey); *Central United's Post-Hearing Proposed Findings of Fact, Conclusions of Law and Order*, (Central United's Post-Hearing Proposed Order), ¶ 18.

28. Lee Ann Blakey testified on behalf of Central United that Central United did not change its internal definition of actual charges. *Tr. 51.* This testimony is inconsistent with the fact that Central United, after February 2003, issued notices specifying that policyholders must submit documents "showing the charges paid by you or on your behalf", *Exhibit E*, and issued new endorsements in October, 2003 containing the definition of actual charge. *Exhibit 1, Final Report.* The testimony is also inconsistent with the fact Central United had for years paid the list price of the providers. *Central United Post-Hearing Proposed Order*, ¶ 27. No notice would have been required to the policyholders if Central United had not changed its interpretation and administration of the actual charges benefits.

29. Central United's February 2003 change in how it administered the benefit provisions of its guaranteed renewable cancer and specified disease health insurance policies impacted, and continues to impact, the benefits paid for claims under the following policies issued and assumed by Central United (*Exhibits 5 and 7*):

a. Central United Policy Forms:
    i. CP-1003-MO
    ii. CP3000AMO
b. Dixie National Life Insurance Company ("Dixie") Policy Forms:
    i. CP-1003

ii. CP-1004
iii. CP-1005

c. Commonwealth National Life Insurance Company ("Commonwealth") Policy Forms:

i. CEP-350-MAX-COMB
ii. CEP-93ULT
iii. CEP-93CONV

30. Nowhere in the following listed advertisements or marketing materials providing for actual charge benefits and in no advertisement or marketing materials of policies that Central United assumed from or administered for Dixie or Commonwealth did Central United disclose that the payment a policyholder would receive would be impacted by the policyholder's primary insurance coverage:

a. Form CP-1005-Rev.3/88, which advertised Policy Form CP-1005;
b. Form NCP-2-(Rev.9/92), which advertised Policy form CP-1004;
c. Form BCEP-94, which advertised Policy Form CEP-93ULT;
d. Form CP-1003-GN-7/96, which advertised Policy Form CP-1003; and
e. Forms CP300A 0102-MO and CP300A-CC-0202 (AR, IL, MO), which advertised Policy Form CP3000.

Exhibit 1, Final Report, pp. 6 – 10; Exhibits 5 & 6, Advertising materials; Exhibits H & I, Dixie advertisement.

31. Lee Ann Blakey testified that the amount paid by Central United for an actual charge benefit would depend on the policyholder's major medical policy in that the actual charge amount paid may be different. *Tr. 104.* Hence, Central United's advertisements claiming such language as "**Pays in addition to all other insurance**" (*e.g., Exhibit* G, bold in original) and "**pays regardless of other insurance you may have!**" (*e.g., Exhibit J*, bold and underline in original), fails to inform that the actual charges benefits do, in fact, depend on the level of coverage provided by the policyholder's "other insurance".

32. In December, 2003, Central United began to use and market a new policy form which contained a written definition of "actual charge." *Exhibit 1, Final Report.*

33. In its Proposed Findings of Fact, Conclusions of Law and Order, Central United does not assert that Sections III (Claim Practices), IV (Complaints) or V (Criticisms & Formal Request Time Study) of the Final Report should be rejected or modified. *Central United's Post-Hearing Proposed Order*, p. 28.

34. Central United failed to complete its investigation of 29 claims within 30 days after notification of the claim, although the investigations could reasonably have been completed within this time, in violation of 20 CSR 100-1.040 (as amended, 20 CSR 100-1.050). *Exhibit 1, Final Report*, p. 15.

35. Central United failed to advise claimants of the acceptance or denial of 57 claims within 15 working days of receipt of all forms necessary to establish the nature and extent of the claims, in violation of 20 CSR 100-1.050(1)(A). *Id.* at 15 – 16.

36. Central United improperly reduced a policyholder's benefits, in violation of 20 CSR 100-1.020(1). *Id.* at 16.

37. Central United failed to include one complaint in it its Company Complaint Log, in violation of 20 CSR 300-2.200(3)(D) (as amended, 20 CSR 100-8.040(3)(D). *Id.* at 18.

38. Central United failed to respond to three criticisms and one formal request within 10 calendar days after receipt. *Id.* at 19.

39. Central United presented evidence that employees of the Department's Consumer Affairs Division corresponded with consumers and Central United where the consumer complained regarding the amount of paid benefits by Central United. *Exhibit W, October 21, 2003 Carol Harden letter to consumer complainant; Exhibit X, August 29, 2005 Harden letter to consumer complainant; Exhibit Y, August 26, 2005 Mary Kempker letter to consumer complainant; Exhibit Z, September 13, 2005 Harden letter to Central United; Exhibit AA, August 9, 2005 Central United letter to Harden.*

40.. Carol Harden testified for Central United pursuant to a subpoena issued by the hearing officer. In 2004, Carol Harden was employed by the Department in the Consumer Affairs Division, Consumer Services Section, as a consumer services specialist. *Tr. 195 – 95* (Harden). At that time, Harden reported to Mary Kempker who was the Director of the Division of Consumer Affairs. *Id.* at 195.

41. John McGettigan, Senior Vice President and General Counsel of Central United, testified: "Our company received those letters [from Harden and Kempker] and relied on the Department's statements in the letters that the company was paying claims accurately by paying the actual charge." *Tr. 229.* McGettigan's testimony regarding reliance is not credible. The correspondence in Exhibits W through Z occurred months, or even years, after Central United changed its administration of actual charge benefits in its policies on February 1, 2003. Additionally, Central United received the notice of the Division's market conduct examination in October, 2004, for an exam covering January 1, 2002 through December 31, 2004. *Tr. 243*(McGettigan); *Exhibit 1, Final Report,* p. 4.

42. Harden testified that Consumer Services, [within the Division of Consumer Affairs] cannot require an insurer to do anything. *Tr. 214.* If Consumer Services feels that an insurer is not in compliance, it can refer the matter to Market Conduct [Division of Insurance Market Regulation]. *Id.*

III. CONCLUSIONS OF LAW

A. Jurisdiction and Authority

43. The Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration has the duty to administer Chapter 354 and Chapters 374 to 385 RSMo, including the supervision, regulation and discipline of insurance companies authorized to operate and conduct business in Missouri.

44. The authority of the Division within the Department to perform a market conduct examination includes, but is not limited to §§ 374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009

45. The jurisdiction of the Director to initiate and administer this proceeding is found in § 374.205.3 RSMo 2000 and 20 CSR 100-8.018.

46. The Director had authority pursuant to 20 CSR 800-1.130 to appoint a hearing officer to conduct the hearing requested by Central United under 20 CSR 100-8.018(1)(F). Once the hearing is completed, the hearing officer shall recommend findings of fact, conclusions of law and a final order to the Director. The Director shall dispose of the matter. 20 CSR 800-1.130; *see also* § 374.205 and 20 CSR 100-8.018(1)(F) and (G).

47. After a hearing under 20 CSR 100-8.018(1)(F), "the director shall issue final examination findings; and"

> (G) Within thirty (30) days of the end of the period allowed for the receipt of an acceptance or comments by the company or following a hearing, the director shall fully consider and review the report, together with any written comments and any relevant portions of the examiner's work papers and enter an order:
>
> 1. Accepting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the director, the director may issue an order for any legal or regulatory action as the director deems appropriate, provided that this order shall be a confidential internal order directing the department to take certain action, or the company and the division may negotiate a consent order, curative order, or settlement agreement. Any such order or agreement shall be final once issued or approved by the director;
>
> 2. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional documents, data, information, and requiring the submission of either a new report or a supplemental report; or
>
> 3. For an investigatory hearing with no less than twenty (20) days' notice to the company for purposes of obtaining additional documents, data, information, and testimony.

* * *

(3) All orders entered pursuant to subsection (1)(G) shall be accompanied by findings and conclusions resulting from the director's consideration and review of the examination report, relevant examiner work papers, and written submissions, rebuttals, or comments, if any submitted by the company. A finding issued under subsection (1)(F) shall not be considered a final order. Any order issued under paragraph (1)(G)1. shall be considered a final administrative decision and may be appealed pursuant to section 374.055, RSMo, Chapter 536, RSMo, and 20 CSR 800-1.100 and shall be served upon the company by certified mail, together with a copy of the final examination report. Within thirty (30) days of the issuance of the final findings, as outlined in subsection (1)(G), the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the final report and related orders.

20 CSR 100-8.018(1)(F), (G) and (3).

47. "Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action." § 374.205.2(5).

48. Section 375.445 RSMo 2000 states:

1. When upon investigation the director finds that any company transacting business in this state has conducted its business fraudulently, is not carrying out its contracts in good faith, or is habitually and as a matter of business practice compelling claimants under policies or liability judgment creditors of the insured to either accept less than the amount due under the terms of the policy or resort to litigation against the company to secure payment of the amount due, and that a proceeding in respect thereto would be in the interest of the public, he shall issue and serve upon the company a statement of the charges in that respect and a notice of a hearing thereon.

2. If after the hearing the director shall determine that the company has fraudulently conducted its business as defined in this section, he shall order the company to cease and desist from the fraudulent practice and may suspend the company's certificate of authority for a period not to exceed thirty days and may in addition order a forfeiture to the state of Missouri of a sum not to exceed one thousand dollars, which forfeiture may be recovered by a civil action brought by and in the name of the director of insurance. The civil action may be brought in the circuit court of Cole County or, at the option of the director of insurance, in another county which has venue of an action against the person, partnership or corporation under other provisions of law. The director of insurance may also suspend or revoke the license of an insurer or agent for any such willful violation.

49. Section 375.934 states that it is an unfair trade practice for any insurer to commit any practice defined in § 375.936 if:

(1) It is committed in conscious disregard of §§ 375.930 to 375.948 or of any rules promulgated under those section.
(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

§ 375.934 RSMo 2000.

50. Pursuant to § 975.936, any of the following practices, if committed in violation of § 375.934 are defined as unfair trade practices in the business of insurance:

(6) "Misrepresentations and false advertising of insurance policies", making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

* * *

(13) Any violation of section 375.445.

§375.936 RSMo 2000.

51. Section 376.777.7(3) RSMo 2000 states:

(3) The director of the department of insurance, financial institutions and professional registration shall approve only those policies which are in compliance with the insurance laws of this state and which contain such words, phraseology, conditions and provisions which are specific, certain and unambiguous and reasonably adequate to meet needed requirements for the protection of those insured. The disapproval of any policy form shall be based upon the requirements of the laws of this state or of any regulation lawfully promulgated thereunder.

52. Section 376.780 states:

1. Other policy provisions. No policy provision which is not subject to section 376.777 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 376.770 to 376.800.

2. Policy conflicting with sections 376.770 to 376.800. A policy delivered or issued for delivery to any person in this state in violation of sections 376.770 to 376.800 shall be held valid but shall be construed as provided in sections 376.770 to 376.800. When any provision in a policy subject to sections 376.770 to 376.800 is in conflict with any provision of sections 376.770 to 376.800, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 376.770 to 376.800.

53. Rule 20 CSR 400-5.700(5)(A)1 states:

(5) Advertisements of Benefits Payable, Losses Covered or Premiums Payable.

(A) Deceptive words, phrases or illustrations are prohibited.

1. No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of this information or use of these words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied or does not remedy misleading statements or omissions of pertinent fact. No advertisements may employ devices which create undue fear or anxiety in the minds of its readers judged by the standards in section (4).

B. Conclusions of Law Relating to the Final Examination Report

54. Central United has the burden of demonstrating that the Final Report should be modified or rejected, as requested. 20 CSR 100-8.018(1)(F). Central United has not met its burden.

55. Central United's attempt to change the terms of its policy, #CP3000AMO, with Endorsement Form CP3ACEND, was ineffective. Central United's policies were guaranteed renewable and could not be unilaterally modified by Central United without the policyholders' consent and an exchange of consideration. Central United violated § 375.934 by engaging in unfair trade practices as defined in § 375.936, by committing the violations defined in § 375.936(13) with such frequency to indicate a general business practice to engage in that type of conduct.

56. Central United's unilateral imposition of a new contractual term and change in its claims administration for "actual charge" policies is fraudulent, amounts to a failure to carry out its contracts in good faith, and compels claimants to accept less than the amount due under the terms of their policy, in violation of § 375.445 and in violation of § 375.936(13).

57. Central United's change in its interpretation of the term "actual charge" and the manner in which Central United was administering claims effective February 2003 highlighted an ambiguity in Central United's policy forms. When there is an ambiguity in an insurance contract, the contract must be construed in favor of the policyholder. *Jones v. Mid-Century Ins. Co.*, 2009 WL 1872113, at *2 (Mo. June 30, 2009).

58. Section 376.777.7(3), RSMo, prohibits ambiguities in individual health insurance policies. For the policy forms to comply with §§376.777.7(3) and 376.780.2, RSMo, Central United was under an obligation to interpret the undefined term "actual charges" in the manner

most favorable to the insured. By adopting and implementing the less favorable interpretation and claims administration procedures for those policies where "actual charges" was undefined, Central United violated § 376.780 by delivering policies Central United implicitly agrees are not in conformance with § 376.777.7(3).

59. Because Central United changed how it administered claims so that the amount paid on a claim depended on the amount the provider accepted as payment in full from the policyholder's "other insurance," rather than the billed amount, the policyholder's benefit under the Central United policy was adversely affected by any "other insurance" he or she may have in addition to the Central United policy. As a result of the change in the manner in which Central United administered its claims, any benefit payments that were based on a provider's "actual charge" were limited to whatever lower amount the provider agreed to accept from the policyholder's primary health plan, Medicare, or other third party payer.

60. Central United's failure to disclose that the policyholder's actual charges benefits were affected by "other insurance" made Central United's marketing and advertising of its policy forms incomplete, deceptive, ambiguous and a misrepresentation of the benefits, advantages, conditions, or terms of the policies, in violation of §375.936(6) and 20 CSR 400-5.700(4) and (5)(A)1. Where the advertisements claimed that the benefits would be "in addition to" or "regardless" of other insurance, it is reasonable for an consumer to believe that they would be required to pay what a doctor bills, or what they would actually be charged in the absence of other insurance.

61. Central United's marketing and advertising of ambiguously worded policy forms between February 1, 2003, and July 1, 2003, through uninformed producers constitutes a violation of § 375.934 by engaging in unfair trade practices as defined in § 375.936, by committing the violations defined in § 375.936(6) with such frequency to indicate a general business practice to engage in that type of conduct.

62. Missouri law prohibits any insurance company transacting business in Missouri from conducting its business fraudulently, carrying out its contracts in bad faith, or compelling insured to accept less than the amount due under the terms of their policy. § 375.445. Central United engaged in such conduct which constitutes a violation of § 374.445 and is an unfair trade practice pursuant to § 375.934, committed with such frequency to indicate a general business practice to engage in such conduct. § 376.936(13), RSMo.

63. Central United assumed the block business of Dixie in 1996 and of Commonwealth in 1997. Central United's failure, when purchasing these blocks of business, to recognize the change in medical billing and reimbursement cannot be shifted to the shoulders of its policyholders.

64. Central United's witnesses Blakey, Chapman, and Morrisey testified that the changes in medical billing, dating back to at least the 1980s, necessitated the changes in the administration of actual charges benefits. This testimony does not address the fact that Central United did not attempt to change its administration of actual charges benefits until 2003.

65. Central United failed to complete its investigation of 29 claims within 30 days after notification of the claim, although the investigations could reasonably have been completed within this time, in violation of § 375.1007(3) and 20 CSR 100-1.040 (as amended 20 CSR 100-1.050(4), eff. 7/30/08)).

66. Central United failed to advise claimants of the acceptance or denial of 57 claims within 15 working days of receipt of all forms necessary to establish the nature and extent of the claims, in violation of § 375.1007(3) and 20 CSR 100-1.050(1)(A).

67. Central United improperly reduced a policyholder's benefits, in violation of 20 CSR 100-1.020(1).

68. Central United failed to include one complaint in it its Company Complaint Log, in violation of § 375.936(3) and 20 CSR 300-2.200(6), (as amended 20 CSR 100-8.040(6), eff. 7/30/08)).

69. Central United failed to respond to three criticisms and one formal request within 10 calendar days after receipt, in violation of § 374.205.2(2) and 20 CSR 300-2.200(6), (as amended 20 CSR 100-8.040(6), eff. 7/30/08)).

C. Resolution of Other Legal Issues

70. In its Proposed Order, Central United would have the Director declare Section II of the Final Report as invalid because:

> [T]he Director is estopped to assert and apply an interpretation of actual charges as meaning billed charges and to penalize Central United on that basis due to prior authorized statements and acts of Department agents and employees, upon which Central United relied. The Report attempts to find violations for Central United's payment of "actual charges" claims based the amount actually paid for a service. However, the evidence indicates that agents and employees of the Department made prior statements and took action in direct contradiction to the findings and conclusions in Section II of the Report . . . .

Central United Post-Hearing Proposed Order, ¶ 95. Central United then lists the correspondence between employees of the Division of Consumer Affairs and Central United Life and consumer complainants (policyholders). Central United goes on to claim that it "relied upon these statements and actions of the Department[,] that its reliance was reasonable under the circumstances and that [Central United] will be injured if the contradictions contained in Section II of the Report are permitted." *Id.*, ¶ 96.

71. The case law in Missouri amply demonstrates the persistent prevalence of the general principle of no estoppel against the government and a recitation of such case law will not be repeated here. The requirements for applying estoppel to government agencies is set forth in *Bailey v. City of Goodman,* 69 S.W.3d 154 (Mo. App. 2002).

> A party asserting estoppel must prove all required elements of estoppel in order to prevail. These elements are 1) a statement or act by the government entity inconsistent with the subsequent government act; 2) the citizen relied on the act; and 3) injury to the citizen. In addition, the governmental conduct complained of must amount to affirmative misconduct.

Id. at 157 (internal citations omitted). Equitable estoppel may run against the state, but only where there are exceptional circumstances and a manifest injustice will result. *Prince v. Division of Family Services*, 886 S.W.2d 68, 73 (Mo. App. 1994). Equitable estoppel is not applicable if it will interfere with the proper discharge of governmental duties, curtail the exercise of the state's police power or thwart public policy, and is limited to those situations where public rights have to yield when private parties have greater equitable rights. *State ex rel. Capital City Water Co. v. Missouri Public Service Comm'n*, 850 S.W.2d 903, 910 (Mo. App. 1993); *compare Twelve Oaks Motor Inn, Inc. v. Strahan*, 110 S.W.3d 404, 408 (Mo. App. S. D. 2003) (court estopped the government from denying the timeliness of an appeal of a tax assessment where the government had erroneously informed the taxpayer as to the deadline for filing the appeal and where the timely appeal of the tax assessment, did not involve a substantive public policy) *with Fraternal Order of Police Lodge No. 2 v. City of St. Joseph*, 8 S.W.3d 257, 263-264 (Mo. App. W. D. 1999) (appellants failed to meet their burden of proving affirmative misconduct and the case dealt with substantive public policy regarding the solvency of the police pension fund).

72. Central United has not proven the required elements of estoppel against the Director, Department or Division. As a matter of fact and law, nothing in the correspondence is a representation or assurance to either the consumer or Central United upon which they could reasonably rely. Central United does not and cannot assert "affirmative misconduct" by the Director, Department or Division. This is especially true where Central United decided before February, 2003 to change its actual charge claims procedures, which is nine months before the earliest correspondence, Exhibit W. No injury could have resulted to Central United based upon the correspondence because it had already changed its procedures and was notifying policyholders. As stated in the Findings of Fact, John McGettigan's testimony that Central United relied upon the correspondence of the Department's employees is not credible.

73. The Director, Department, and Division are charged with enforcing the insurance laws of the state of Missouri. Estoppel will interfere with the proper discharge of governmental duties and thwart public policy of protecting Missouri insurance consumers. There is a case directly on point to Central United's argument. In *Traders Mutual Fire Insurance Company v. Leggett*, 284 S.W.2d 586 (Mo. 1955), an insurance company argued that past knowledge and implicit approval by the insurance department of the insurance company's business precluded the insurance department's attempt to enjoin such business:

> It is claimed, by reason of its annual reports and the department's examinations, that the department long had knowledge of the fact that the company was writing automobile insurance and that the department's knowledge and actions in these respects constituted an administrative construction of the statutes and the company's charter and should be given some weight indicative of the company's power to write that class of insurance. But aside from the meagerness of the record and the inconclusiveness of the facts shown, the knowledge or tacit

> consent of the department would not make the company's act of writing automobile insurance lawful if in point of fact the writing of such insurance was unauthorized and unlawful.

Id. at 588 – 589.

74. In its Post-Hearing Proposed Order, Paragraph 83, Central United argues that the Final Report must be rejected because it contradicts the final judgment in a class action proceeding styled *Cora Skelton and Stephen McKnight v. Central United Life Insurance*, Civil Action No. CV-2008-900178 in the Circuit Court of Mobile County, Alabama ("*Skelton*"), Exhibit C. Central United cites to Article IV, § 1 of the United States Constitution which states, in pertinent part: "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State."

75. Central United goes on to state that the parallel provision of Missouri state law is located in section 490.130, RSMo, and that "full faith and credit" applies to state administrative bodies as much as to state courts, citing *V.M.B. v. Missouri Dental Board*, 74 S.W.3d 836, 841 (Mo. App. W.D. 2002). Central United claims the effect of the *Skelton* judgment given Full Faith and Credit here is that all of the Missouri policyholders alleged by the Department to have been subject to unfair practices relating to "actual charges" have been compensated and have released all claims against Central United relating to these matters. The meaning of "actual charges" has been adjudicated as between the parties to these policies and all claims relating thereto released by the policyholders. Central United quotes part of the *Skelton* Final Judgment:

> All future claims for actual-charge benefits, submitted by Settlement Class members who did not exclude themselves from the Settlement[2], will be processed and paid actual charges benefits for chemotherapy/ radiation/blood based upon the monetary amount that Central United can determine was the amount paid by or on behalf of the insured, beneficiary or policyholder and accepted as payment in full by the healthcare provider. Central United may require an Explanation of Benefits ('EOB') or proof of loss documentation from the policyholders primary insurance company or Medicare in order to determine that monetary amount.

76. Central United's arguments are misplaced and the full faith and credit clause of the United States Constitution, or as codified in Missouri under § 490.130, has no application to this proceeding. Full faith and credit, as applied to judgments of a state court, makes "that which has been adjudicated in one state res judicata to the same extent in every other." *Magnolia Petroleum Co. v. Hunt*, 320 U.S. 430, 438, 64 S.Ct. 208, 213 (1943); *overruled on other grounds by Thomas v. Washington Gas Light Co.*, 448 U.S. 261, 100 S.Ct. 2647 (1980).

77. Missouri courts give full faith and credit to judgments of sister states except where it can be shown that there was no jurisdiction over the subject matter or over the person or where the judgment was obtained by fraud. *Big Tex Trailer Mfg. v. Duff Motor Co., Inc.*, 275 S.W.3d 384, 386 (Mo. App. W.D. 2009). First, the Alabama court has and had no power to

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[2] Central United's footnote: Only four (4) Missouri policyholders opted out of the class settlement judgment.

decide how the Director of the Department should apply Missouri insurance law to Central United Life's conduct in the state of Missouri. Nowhere in the *Skelton Final Judgment* does the Alabama state circuit court attempt of extend subject matter jurisdiction over the regulatory authority of the Director, Department or Division. The *Skelton* court lacks jurisdiction over the enforcement of Missouri's insurance law against an insurer licensed to do business in Missouri.

78. Second, the Director, Department and/or Division were not parties to the *Skelton* Alabama circuit court action and no litigation occurred in *Skelton* on the issue of personal jurisdiction over the Director, Department or Division. *Miller v. Dean*, 2009 WL 981113 (Mo. App. W.D. April 14, 2009). Moreover, Central United fails to offer a basis for a Missouri state official or governmental entity to be sued and subject to personal jurisdiction in an Alabama state court in a private, class action proceeding. Finally, the fact the Central United's policyholders in Missouri may be bound by the Alabama court's judgment does not assist the insurer in a Missouri administrative proceeding. Simply put, the Missouri policyholders may have no power to require Central United to do anything to the contrary of the judgment of the Alabama court, but the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration does, where permitted by Missouri insurance law.

79. In Paragraph 88 of its Post-Hearing Proposed Order, Central United contends that "[b]y simply concluding ambiguity because [Central United] allegedly changed its practices to process claims based on more accurate EOB information rather than provider list prices the Report fails to apply an appropriate legal standard." Contrary to that contention, however, the record is replete with evidence of ambiguity regarding the meaning of the term "actual charge". If the term was unambiguous, Central United would not have issued endorsements for their older policies and begun marketing new policies with the term defined. If the term was unambiguous, Central United would not have administered the claims on its own and the Commonwealth and Dixie policies as it did for years prior to February 1, 2003, and then abruptly change claims administration. Also, if the term was unambiguous, no new statutes would be needed in various the states defining the term actual charges. *See* Exhibit E (new state statutes) with *Exhibit MM, October 31, 2008 Response of Central United to the August 26, 2008 Report.*

80. Furthermore, several lawsuits have been filed around the country regarding the term at issue. District courts in Alabama and Louisiana have found that the phrase "actual charges" is unambiguous "when given its ordinary and plain meaning in the context of the policy" and that it means "the amount that the insured is legally obligated to pay." *Claybrook v. Central United Ins. Co.*, 387 F.Supp.2d 1199, 1204 (M.D.Ala.2005); *Jarreau v. Central United Ins. Co.*, 2006 WL 2086011, * 1 (M.D.La.2006) (questioned by *Guidry v. American Public Life Ins. Co.*, 512 F.3d 177, 182 (5th Cir. 2007), and *Ward v. Dixie Nat'l Life Ins. Co.*, 257 Fed.Appx. 620, 630 (4th Cir. 2007)). Conversely, the Fifth Circuit and Fourth Circuit have found the phrase "actual charges" as used in a supplemental cancer insurance policy to be ambiguous. *Guidry*, 512 F.3d at 182; *Ward*, 257 Fed. Appx. at 627. The Western District of Oklahoma has also found that the undefined phrase "actual charges" is ambiguous in a limited benefit health insurance policy. *Metzger v. American Fidelity Assurance Co.*, 2006 WL 2792435 at *4-5 (W.D. Okla. Sept. 26, 2006). The Northern District of Mississippi has also held that "the term 'actual charges' as used but not defined in the subject policy means the amount of money the provider typed on the bills and sent to the insured and insurer." *Conner v. American Public Life Ins. Co.*, 448 F.Supp.2d

762, 766 (N.D. Miss. 2006). And very recently, the District Court of Arizona found the term actual charge to be ambiguous and could be interpreted in different ways. *Pierce v. Central United Life Ins. Co.*, 2009 WL 2132690 (D.Ariz. July 15, 2009).

81. In a similar vein, Central United points to the definition of "actual payment" in 20 CSR 400-2.065(1) to support its interpretation of actual charge benefits in its policies. *Central United Post-Hearing Proposed Order*, ¶ 98.c. That regulation states:

> (A) "Actual payment," the real total dollar amount actually paid or to be paid in fact, by a health insurer, or by the health insurer and the insured when the insured is responsible for some part of the cost, to a health services provider for a health service(s) pursuant to a health plan. Annual adjustments in amounts paid to providers which are based on referral rates, quality or cost effectiveness measurements, or other similar contractual provisions may be excluded from the calculation of actual payments, at the option of the health insurer.

82. This citation does not avail Central United for two reasons: (1) the phrase "actual payment" is not at issue in this matter and simply because the word "actual" appears in the phrase, it does not render the phrase sufficiently similar to the term actual charges to provide any guidance, and hence, is irrelevant; and (2) if the term "actual charges" is not ambiguous and is not a term of art as Central United contends, Central United would not need to rely on the definition of a different phrase in a different context to aid in defining the term.

CONFIDENTIAL FINAL ORDER

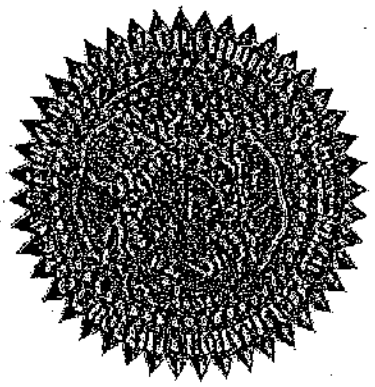
Based upon the substantial and competent evidence in the record and presented at the hearing in this matter, and having read the full record including the Final Examination Report, transcript, written submissions and comments, and all evidence submitted by the parties in this matter, including any relevant portions of the examiner's work papers,

IT IS HEREBY ORDERED that the Final Examination Report of Central United Life Insurance Company (NAIC #61883), Examination #5013-36-TGT, dated July 10, 2009, is hereby accepted as filed, pursuant to 20 CSR 100-8.018(1)(G)1.

Furthermore, because the examination report reveals that the company has operated and is operating in violation of any law or regulation,

IT IS FURTHER ORDERED that the Enforcement Section of the Department is hereby directed to initiate appropriate legal and regulatory actions consistent with the findings contained in the Final Examination Report of Central United Life Insurance Company (NAIC #61883), Examination #5013-36-TGT, dated July 10, 2009, and consistent with these Findings of Fact, Conclusions of Law and Confidential Final Order Accepting Final Examination Report as Filed.

SO ORDERED, SIGNED AND OFFICIAL SEAL AFFIXED THIS 27th DAY OF AUGUST, 2009.



John M. Huff
Director

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing document was forwarded by facsimile, hand-delivery, and certified mail, this 27th day of August, 2009 to:

Sherry L. Doctorian, Esq.
Armstrong Teasdale LLP
3405 West Truman Blvd., Suite 210
Jefferson City, MO 65109

And hand delivered to:

Carolyn H. Kerr, Esq.
Senior Attorney
Insurance Market Regulation Division
Department of Insurance, Financial Institutions
and Professional Registration

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STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

MARKET CONDUCT

FINAL EXAMINATION REPORT

OF THE

CANCER AND SPECIFIED DISEASE HEALTH INSURANCE BUSINESS

OF

CENTRAL UNITED LIFE INSURANCE COMPANY

NAIC NUMBER: 65323

NAIC GROUP CODE: 2398

10700 NORTHWEST FREEWAY, THIRD FLOOR
HOUSTON, TEXAS 77092

STATE OF DOMICILE: TEXAS

July 10, 2009

REPORT NUMBER: 5013-36-TGT

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FOREWORD

This Market Conduct Examination Report is, in general, a report by exception. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Missouri Department of Insurance, Financial Institutions and Professional Registration. In performing this examination, the Missouri Department of Insurance, Financial Institutions and Professional Registration selected a small portion of the Company's operations for review. As such, this report does not reflect a review of all practices and all activities of the Company. The examiners, in writing this report, cited errors made by the Company. The final examination report consists of three parts: the examiners' report, the response of the Company, and administrative actions based on the findings of the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration.

Wherever used in this report:

- "CUL" or "Company" refers to Central United Life Insurance Company;
- "CSR" refers to the Code of State Regulations;
- "DIFP" or "Department" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "NAIC" refers to the National Association of Insurance Commissioners;
- "RSMo" refers to the Revised Statutes of Missouri.

SCOPE OF THE EXAMINATION

The authority of the DIFP to perform this examination includes, but is not limited to, §§374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009, RSMo. In addition, §447.572, RSMo grants authority to the DIFP to determine Company compliance with the Uniform Disposition of Unclaimed Property Act.

The Company examined was Central United Life Insurance Company.

The time period covered by this examination is primarily from January 1, 2002, through December 31, 2004, unless otherwise noted.

The purpose of this targeted examination is to determine whether the Company complied with Missouri laws and DIFP regulations in its marketing, underwriting and administration of cancer and specified disease health insurance policies.

While the examiners reported on errors found in individual files, the examination also focused on the general business practices of the Company. The DIFP has adopted the error tolerance guidelines established by the NAIC. Unless otherwise noted, the examiners applied a 10% error tolerance ratio to all operations of the Company, with the exception of claims handling. The error tolerance ratio applied to claims matters was 7%. Any operation with an error ratio in excess of these criteria indicates a general business practice.

The examination focused on review of the cancer and specified disease health insurance business of the company. The examination included, unless otherwise noted, a review of the following areas of the Company's operations: Sales and Marketing, Underwriting, Claims and Complaints/Grievances.

This market conduct examination was performed at the home office of the Company: 10700 Northwest Freeway, Houston, Texas 77092.

EXECUTIVE SUMMARY

The main issues of concern found by the examiners are as follows:

1. CUL materially changed how it administers the benefit provisions of guaranteed renewable cancer health insurance policies beginning February 1, 2003. The change has impacted the benefits paid for claims under many of the policies issued by CUL as well as benefits paid for claims under many of cancer insurance policies that the Company assumed from or administers for Dixie National Life Insurance Company or assumed from Commonwealth National Life Insurance Company.

   Many of the benefit provisions of the Company's cancer policies are worded to pay benefits based on a health care provider's *actual charge* for covered services. Prior to February of 2003, the Company administered those *actual charge* claims based on the amount health care providers billed for their services. Beginning in February of 2003, the Company administered claims based on a different definition of the term *actual charge*. From that date forward, the Company defined *actual charge* to mean, *"...the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided."* As a result, any benefit payments that were based on a provider's *actual charge* were limited to whatever lower amount the provider agreed to accept from the insured person's primary health plan, Medicare or other third party payer. This change resulted in:

   A. A reduction to the amount of benefits payable,
   B. An increase in the number of consumer complaints,
   C. Increased litigation against the Company,
   D. More time consuming claims processing because the company had to ask claimants to provide EOBs from their primary health plan or their Medicare benefits summary, and,
   E. Unfair discrimination against equally situated policy owners due to differences among their primary health plans.

   The term *actual charge* was not defined in any of the Company's marketing materials or in any of the cancer policies sold in Missouri until October of 2003. It was not until December of 2003 that all cancer policies the company marketed in Missouri that paid one or more benefits based on a health care provider's *actual charge* included a definition of that term.

2. The Company and the DIFP have both received consumer complaints because of the Company's slow payment of claims. Claims investigation and claims payment time studies outlined in this report clearly demonstrate that slow payment of claims is an issue of concern. Consumer complaint files indicate that the changed definition of the term *actual charge*, slow payment of claims (to which that changed interpretation would contribute), and premium rate increases made up the majority of the complaints against the Company during the time frame covered by this examination.

SECTION I

I. SALES AND MARKETING PRACTICES

This section details the examination findings regarding sales and marketing practices. The items reviewed were the Certificate of Authority, product marketing and advertising materials and agent training materials.

A. Company Authorization

Missouri law limits the entities that may sell insurance and the types of insurance they may sell. These limitations exist to protect consumers and ensure that they receive fair treatment from insurers. After an insurer has submitted an application and complied with all requirements to conduct insurance business in Missouri, the DIFP grants a license called a Certificate of Authority.

During the time period covered by the examination, Central United Life Insurance Company had authority to transact business in the following lines of insurance:

* Life, Annuities and Endowments
* Accident and Health

B. Marketing Practices

Missouri law requires that an insurer be truthful and provide adequate disclosure when marketing its insurance products. This includes assuring that its advertisements do not omit information if that omission has the capacity, tendency, or effect of misleading or deceiving potential customers as to the extent of any policy benefits payable. The examiners reviewed Company marketing practices including advertising and agent training materials, to determine whether those materials and marketing practices complied with Missouri law.

The examiners found the following issue in this review:

Many of the cancer insurance policies the Company issued in Missouri, as well as cancer policies issued in Missouri that it assumed from or administered for other insurers, contain benefit provisions that pay benefits based on a health care provider's *actual charge* for covered services. None of the marketing materials used in the solicitation or sale of those policies defined or explained the term *actual charge*.

Before February 1, 2003, the Company, as well as those companies from which it had assumed such policies, administered claims based on *actual charge* meaning the amount billed by the health care provider. From that date forward any benefit

payments that were based on a provider's *actual charge* were limited to whatever lower amount the provider agreed to accept from the insured person's primary health plan, Medicare or other third party payer.

Based on information provided by the Company, it continued to market policy form CP3000AMO until December 2003, although that policy form and its related marketing materials did not define *actual charge* or explain the limiting nature of that terminology. A notice in that regard was not sent to existing policyholders until July 3, 2003.

The company did not begin attaching endorsement form CP3ACEND to new issues of this form to add the definition of *actual charge* until October 16, 2003. Marketing materials used in the solicitation of this policy, however, were never revised.

The only written communication from the company to its agents regarding this change was sent to them sometime in July 2003. That communication consisted only of a copy of the Notice form that had been sent to policyholders on July 3, 2003.

Therefore, between February 1, 2003, and July 1, 2003, the Company marketed an ambiguously worded policy form through misinformed agents (form CP3000AMO).

Reference: § 375.936(6), RSMo, and 20 CSR 400-5.700(5)(A)1.

C. Advertising

No advertisement for cancer policies providing *actual charge* benefits that were issued by the company prior to October 2003, and no advertisement of such policies that the company assumed from or administers for Dixie National Life Insurance Company or assumed from Commonwealth National Life Insurance Company, define or explain the term *actual charge*. Furthermore, the advertising materials did not explain that, after February 1, 2003, the actual amount of benefits payable depended on the claimants' "other" insurance rather than the billed charges.

Review of advertisements from these companies for policies in force during the time frame of this examination, and that pay one or more benefits based on *actual charges*, found the following:

1. Dixie National Life Insurance Company – The Company was able to produce two advertisements used by this company:

   a. Form CP-1005-Rev.3/88 - This ad advertised policy form CP-1005. Under the heading Additional Benefits are six bullet items. The first and last bullet items, "***Pays in addition to all other insurance**" and "***Pays directly to you**", are the only bullet items in bold type.
   b. Form NCP-5-(Rev.9/92) - This ad advertised policy form CP-1004. White text on a black background at the bottom of the third page of this ad, in bold type and in the largest font on the page, reads: "***PAYS IN ADDITION***". Below that, also in

bold type but in a slightly smaller font, reads: **"to any other insurance, private or governmental, including Medicare, and directly to you or whomever you designate. No reduction in benefits at any age."**

The two sentences in bold type in each of these ads imply that benefits of the policy are not affected in any way by other insurance a claimant may have. This characterization of the policy's benefits fail to inform the purchaser that the actual level of benefit does, in fact, depend on the policyholder's "other insurance." Because CUL changed its application of "actual charge," so that the amount paid on a claim depends on the amount the provider accepted as payment in full from the policyholder's "other insurance," rather than the billed amount (as it was paying prior to February 1, 2003), the policyholder's benefit under the CUL policy was adversely affected by any other insurance he or she may have in addition to the CUL policy.

A person with experience in the field of health insurance may understand that each sentence addresses a separate issue. However, because of the overall style and appearance of this ad, an ordinary, prudent consumer would believe that these two sentences should be read together to mean that benefits of the policy are not reduced due to any other insurance they may have no matter how old they become.

This failure to fully inform the customer or potential policyholder of the effect of "other insurance" on the level of coverage provided by the CUL policy had the capacity, tendency, or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the CUL policy.

Reference: §375.936(6)(a), RSMo, and 20 CSR 400-5.700(5)(A)1

2. Commonwealth National Life Insurance Company – The Company was able to produce four advertisements used by this company. Form BCEP-94 advertised policy form CEP-93ULT. On the lower half of page 3 of this ad, below the bolded, large type heading, **"Why does this outstanding policy deserve your consideration"** are six bullet point items in bold type. The second bullet point states: **"It <u>pays regardless</u> of other insurance you may have!"**

   This advertisement directly conflicts with the Company's new interpretation of *actual charge*. This advertisement clearly illustrates the intention of the issuing company to pay *actual charge* benefits based on the amount of a provider's bill for covered services.

   Reference: §375.936(6) (a), RSMo.

3. Central United Life Insurance Company – The Company provided two advertisements of its policies:

a. Form CP-1003-GN-7/96. At the bottom of the second page, in the second largest font that appears on the page and in bold type, is the same wording as described in 1b, above, although in black type on a white background: "PAYS IN ADDITION" **to any other insurance, private or governmental, including Medicare, and directly to you or whomever you designate. No reduction in benefits at any age."**

A person with experience in the field of health insurance may understand that the two sentences address separate issues. However, because of the overall style and appearance of this ad, an ordinary, prudent consumer would have believed that these two sentences should be read together to mean that benefits of the policy are not reduced due to any other insurance they may have no matter how old they become.

Additionally, this characterization of the policy's benefits fail to inform the purchaser that the actual level of benefit does, in fact, depend on the policyholder's "other insurance." This failure to fully inform the customer or potential policyholder of the effect of "other insurance" on the level of coverage provided by the CUL policy had the capacity, tendency, or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the CUL policy.

Reference: §375.936(6)(a), RSMo, and 20 CSR 400-5.700(5)(A)1

b. Form CP-1004-GN-7/96 - The front cover page of this ad includes a list of six items that describe what the policy pays. The second item in this list states, "*PAYS* in addition to any other policy you might own."

This ad implies that benefits of the policy are not affected in any way by other insurance a claimant may have. Again, the Company's failure to fully inform the customer or potential policyholder of the actual effect of "other insurance" on the level of coverage provided by the CUL policy had the capacity, tendency, or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the CUL policy.

Reference: §375.936(6)(a), RSMo, and 20 CSR 400-5.700 (5)(A)1

A review of advertisements the company used after January 1, 2003, to market policies that provide one or more benefits based on the *actual charge* for a covered service found the following:

1. Outlines of Coverage form CP 3000AMO-OC – This outline of coverage was used in the sale of cancer policy form AP3000AMO after the date the Company changed how it defines *actual charge*. These outlines of coverage do not define or explain the term *actual charge*.

2. CP3000A 0102-MO – The following statement appears in bold type on the bottom of page 2 of this brochure, in a font that is consistent with the font used for other text on that page: "**PAYS IN ADDITION to any other insurance, private or government, including Medicare, and directly to you or whomever you designate.**" The brochure does not include a definition or explanation of the term *actual charge*.

3. CP3000A-CC-0202 (AR, IL, MO) – Language at the top of page 2 is substantially similar to language in form CP3000A 0102-MO, as shown above.

Reference: 20 CSR 400-5.700(5)(A)1

SECTION II

II. UNDERWRITING PRACTICES

This section of the report details the examination findings regarding underwriting practices.

To minimize the duration of the examination, while achieving an accurate evaluation of the issues of concern examiners limited their review to a review of policy forms.

A. Forms and Filings

The examiners reviewed policy form documents and related forms to determine if the Company complied with Missouri law and requirements for the filing, approval and content of policy forms and related forms. Those forms were also reviewed to ensure that the contract language used is not ambiguous and is adequate to protect the consumer.

The examiners found the following errors in this review:

No cancer insurance policy forms that the Company issued or renewed in Missouri from the beginning of the period covered by this examination (1/01/02) through October 16, 2003, that based one or more benefits on the provider's *actual charge* for covered services, contained a definition of the term *actual charge*. Policies the Company sold or that it assumed from Dixie National Life Insurance Company and Commonwealth National Life Insurance Company had been sold and administered such that *actual charges* meant the amount the provider billed for the covered service. The intent of these companies to pay *actual charge* benefits based on the amount billed by the provider is clear upon review of those forms and related advertising.

When any of these insurers chose to further limit the amount of policy benefits payable for a covered service, whether the benefit provision was worded to pay based on the *actual charge or usual and customary* charge these companies did so by placing specific dollar limits on the maximum amount payable, or, in the case of benefits for surgery, by limited benefits to a surgical fee schedule.

Prior to February 2003, there was no ambiguity in such policies issued by the Company, or in like policies assumed from or administered for Dixie National Life Insurance Company and Commonwealth National Life Insurance Company, because claims filed for *actual charge* benefits were consistently adjudicated on the basis of the health care provider's billed charge. That was no longer the case when the Company implemented its decision to change how it defined the term *actual charge* beginning February 1, 2003.

The Company sent "IMPORTANT NOTICE REGARDING CANCER CLAIMS" to all owners of *actual charge* policies on July 1, 2003. This was the first communication from the Company to policyholders concerning its new interpretation of *actual charge*. That notice explained the Company's new interpretation of *actual charge* and informed policyholders that, because of this change, Explanation of Benefit forms (EOBs), Medicare Benefit Summaries or similar documents would be required as part of proofs of loss to show the amount of money a provider agreed to accept as full payment for covered services.

In addition, the policy forms that provide one or more benefits based on a provider's *actual charge*, but do not contain a definition of that term, have become ambiguous and no longer meet the standards under which they had been approved, as set forth in §376.777.7, RSMo. The Company continued to market policy form CP3000 AMO until December 2003.

New issues of policy form CP3000 AMO were not amended or revised to include a definition of *actual charge* until endorsement form CP3ACEND was mailed to existing Central United Life Insurance Company policy holders on October 16, 2003, and attached to new issues of that policy form from that date forward.

Pursuant to the provisions of §376.780, RSMo, "A policy delivered or issued for delivery to any person in this state in violation of sections 376.770 to 376.800 shall be held valid but shall be construed as provided in sections 376.770 to 376.800. When any provision in a policy subject to sections 376.770 to 376.800 is in conflict with any provision of sections 376.770 to 376.800, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 376.770 to 376.800."

Finally, the company had no contractual right to change in-force policies by endorsement, using form CPA3CEND without the signed consent of policy owners. All of those policies were guaranteed renewable. Each policy owner was entitled to maintain their policy in force as issued, so long as they paid the required premium.

Reference: §§375.445, 376.777.7, and 376.780, RSMo.

For all of the reasons stated above the Company should re-process, and pay, based on the provider's billed charge, all claims filed on all such policies issued before October 16, 2003, for which benefits were payable based on the provider's *actual charge* unless:

1. The Company can show that the policy under which claim was filed has contained a definition of the term actual charges since the date of issue, that definition is consistent with the way the claim was adjudicated, and any amendments to the policies were agreed to by the policy owners; or

2. Claims for *actual charge* benefits were paid based on the provider's billed charges.

The following lists, for each company, the form numbers of the policy forms that were issued in Missouri to claimants of one or more of the 200 claims files reviewed during this examination Each of these policies provide one or more benefits based on a provider's actual charge but none of these policies define or explain that term:

1. Central United Life Insurance Company –

   Forms: CP-1003-MO, CP3000 AMO and CP-1004-GN-7/96

2. Dixie National Life Insurance Company –

   Forms: CP-1003, CP-1004 and CP-1005

3. Commonwealth National Life Insurance Company –

   Forms: CEP-350-MAX-COMB
   CEP-93ULT
   CEP-NP93-MO
   CEP-93CONV
   CEP-120-REV-487 *
   CEP-200-GP/NGP-MO *

   * Although both of these policies pay *actual charge* benefits for various inpatient services such as drugs, attending physician visits, private duty nursing services and inpatient and outpatient lab services, these benefits are subject to very limited daily or per occurrence dollar limits.

SECTION III

III. CLAIM PRACTICES

This section of the report details examination findings regarding Central United Life Insurance Company's claim practices. The examiners reviewed such practices to determine whether claims submitted to CUL are efficiently processed and accurately paid, and for adherence to contract provisions, Missouri law and DIFP regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners reviewed a statistical sampling of the claims processed. A claim file, as a sampling unit, is defined as an individual demand or request for payment or action under an insurance contract. Benefits may or may not be payable under the contract when the request or demand is made.

The most appropriate statistic to measure compliance with Missouri law and DIFP regulations is the percentage of files found to be in error. A claim error includes, but is not limited to, any of the following:

- An unreasonable delay in the acknowledgement of a claim.
- An unreasonable delay in the investigation of a claim.
- An unreasonable delay in the payment or denial of a claim.
- A failure to calculate claim benefits correctly.
- A failure to comply with Missouri law regarding claim settlement practices.

A. Claims Time Studies

In order to determine the efficiency of claims processing, the examiners reviewed claim records and calculated the amount of time taken by the Company to: (1) acknowledge the receipt of notification of claims, (2) investigate claims; and (3) make payment or provide an explanation for the denial of claims.

DIFP regulations provide for the following time requirements in non-assigned claims processing. The company must:

- Acknowledge receipt of notification of a claim within 10 working days.
- Provide instruction and reasonable assistance so that first party claimants can comply with policy conditions and reasonable insurer requirements.
- Complete investigation of a claim within 30 calendar days after notification of the claim.
- Pay or deny a claim within 15 working days of receipt of all forms necessary to establish the nature and extent of the claim.

Cancer Insurance Policy Claims Time Studies

Field Size: 11,374
Sample Size: 200
Type of Sample: Random

1. Acknowledgement Time Study

Insurers are required to acknowledge receipt of notification of a claim within 10 working days.

Working Days	Number of Claims	Percent
0-10	200	100%
Over 10	0	0%
Total		100%

Examiners found no errors in this review.

2. Investigation Time Study

The company failed to complete its investigation of 29 claims within 30 days after notification of the claim, although the investigations could reasonably be completed within this time.

Calendar Days	Number of Claims	Percent
0-30	171	85.5%
Over 30	29	14.5%
Total		100%

Error Ratio: 14.5%

Reference: 20 CSR 100-1.040 (as amended 20 CSR 100-1.050)

Note: Each of the 29 above referenced claims is also among the exceptions noted in the following Determination Time Study.

3. Determination Time Study

The Company failed, in 57 of the 200 claims sampled, to advise claimants of the acceptance or denial of their claim within 15 working days of receipt of all forms necessary to establish the nature and extent of those claims

Working Days	Number of Claims	Percent
0-15	143	71.5%
Over-15	57	28.5%
Total		100%

Error ratio: 28.5%

Reference: 20 CSR 100-1.050(1) (A)

B. **General Handling Practices**

The examiners reviewed Company claim processing practices to determine adherence to its contract provisions and compliance with Missouri law and regulations.

The following are the results of this review:

1. The company offered policy holders the option to accept an endorsement to their policies that reduced benefits for chemotherapy and radiation by 50%. This endorsement was offered in lieu of a pending rate increase.

   The owner of policy form 72 19305 elected to accept the endorsement, but not until after the date expenses were incurred for chemotherapy. The company improperly reduced benefits 50% although services were received prior to the endorsement's effective date.

   The company acknowledged this error and remitted a check for $13,727 to the policy holder for the actual amount due, plus interest.

   Reference: 20 CSR-100-1.020(1)

3. The Company provided examiners with copies of the claim files for claims that had been denied because claimants failed to provide a copy of a Medicare Benefit Summary or an EOB from the insured's primary health plan. Upon review of those files, it appeared to examiners that some claimants submitted documents that provided sufficient information for the Company to have determined its liability for the *actual charge* benefits covered by the policies.

   Request # 23 asked the Company to review 10 of those claim files to determine if sufficient information had been provided to have allowed payment of those claims. CUL reviewed those files and reconsidered and paid the following four claims.

	Block #	Policy #	Claimant #	Claim #	Date Paid	Amount Paid
2	72	13487	OO2	6001	3/29/2006	$8,909
3	83	A05118400	OO1	6001	3/29/2006	$8,400
4	83	A05128220	OO1	6001	3/27/2006	$478
5	83	A05415830	OO1	6001	3/27/2006	$1,590

SECTION IV

IV. COMPLAINTS

This section of the report details the examination findings regarding complaints and grievances against the Company. Missouri law requires insurers to maintain a register of all complaints/grievances received and to retain the documentation on the handling of these complaints. The examiners reviewed 32 complaints submitted directly to the Company or through the DIFP for calendar years 2002, 2003 and 2004. No errors were found in that review.

However, one complaint was found in the Company's claim files that were not included on the Company's Complaint Log.

Reference: 20 CSR 300-2.200(3)(D) (as amended, 20 CSR 100-8.040(3)(D), eff. 7/1/08)

SECTION V

V. CRITICISM & FORMAL REQUEST TIME STUDY

This study reflects the amount of time taken by the Company to respond to criticisms and requests submitted by the examiners.

A. Criticism Time Study

Calendar Days	Number Criticisms	Percentage
0-10	4	57%
Over 10	3	42%
Total	7	100%

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
0 -10	25	96%
Over-10	1	4%
Total	26	100%

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EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Central United Life Insurance Company (NAIC #2398-65323), Examination Number 5013-36-TGT. This examination was conducted by Jim Mealer, and Jim Casey. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated August 26, 2008. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

Michael W. Woolbright 7/10/09

Michael W. Woolbright Date
Chief Market Conduct Examiner

Sherry L. Doctorian

ARMSTRONG TEASDALE LLP

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MISSOURI | KANSAS | ILLINOIS | NEVADA | NEW YORK, NY | WASHINGTON, DC | SHANGHAI | SYDNEY
ATTORNEYS AT LAW

August 11, 2009

VIA HAND-DELIVERY

John Huff, Director
Missouri Department of Insurance, Financial
Institutions and Professional Registration
Truman State Office Building
301 West High Street, Room 530
Jefferson City, MO 65102

Re: Missouri Market Conduct Examination #5013-36-TGT
Central United Life Insurance Company (NAIC #65323)

Dear Mr. Huff:

Pursuant to 20 CSR 100-8.018(1)(F), I write on behalf of Central United Life Insurance Company (CULIC) to request an additional thirty (30) days in which to consider the options listed in said regulation concerning the above-referenced market conduct examination report. Although there have been substantive attempts to discuss settlement, we still have a ways to go to finalize any settlement. Due to summer vacations, an ongoing discussion of this new regulation, the possibility of a bifurcated settlement, and other interruptions, the Company requires additional time in which to consider all of its options.

Your consideration of this request is greatly appreciated.

Very truly yours,

ARMSTRONG TEASDALE LLP

Sherry L. Doctorian

SLD/aw
cc: Carolyn Kerr, Esq.
John McGettigan, Esq.

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Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

Office of the Director

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August 12, 2009

Via Facsimile Only
573.636.8457

Sherry L. Doctorian
Armstrong Teasdale LLP
3405 West Truman Blvd., Suite 210
Jefferson City, Missouri 65109

Re: Missouri Market Conduct Examination #5013-26-TGT
Central United Life Insurance Company

Dear Ms. Doctorian:

I am in receipt of your letter dated August 11, 2009, and delivered to the Department at approximately 5:00 p.m., requesting a thirty (30) day extension of time for your client to consider its options in response to the above-referenced Market Conduct Examination. The request for additional time is denied. As I understand it, your client initially received this Examination on September 8, 2008, and over the intervening months requested two extensions of time. It would appear that your client has had sufficient time to consider its options.

Naturally I regret it if this decision causes you or your client any inconvenience.

Sincerely,

John M. Huff
Director
Department of Insurance, Financial
Institutions and Professional Registration

Sherry L. Doctorian

ARMSTRONG TEASDALE LLP

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ATTORNEYS AT LAW

April 16, 2009

Carolyn Kerr, Esq.
Missouri Department of Insurance, Financial
Institutions and Professional Registration
Truman State Office Building
301 West High Street, Room 530
Jefferson City, MO 65102

Re: Central United Life Insurance Company – Market Conduct Examination

Dear Carolyn:

This will confirm our conversation regarding my request for an extension of time to respond to the Department's report following the market conduct examination of Central United Life Insurance Company. You have agreed to a two-week extension, which makes our response due on or before May 1, 2009. 5/22

Your professional courtesies in this regard are greatly appreciated.

Very truly yours,

ARMSTRONG TEASDALE LLP

Sherry L. Doctorian

SLD/aw
cc: John McGettigan, Esq.

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